

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018278  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2714

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Northeast Restorium</b>		Length of stay in lb <b>56 yrs.</b>	d) STREET ADDRESS (If outside, give location) <b>2332 Kensington</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>F.</b> Last <b>Ireland</b>			4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>		
--	--	--	---	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1886</b>	9. AGE (In years last birthday) <b>72</b>	FUNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
-----------------------	----------------------------------	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Shop</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Marshall, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
--	--	---	---

13a. FATHER'S NAME <b>Richard Ireland</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Martin</b>	14. NAME OF HUSBAND OR WIFE <b>Myra Ireland</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>497-36-4322</b>	17. INFORMANT <b>Myra Ireland</b>	Address <b>2332 Kensington</b>
--	---	--------------------------------------	-----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>1621</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
---	---

20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Jackson</b>	STATE <b>Mo</b>
--	---	---	--	--------------------------	--------------------

21. I attended the deceased from <b>April 1958</b> to <b>May 1958</b> and last saw her alive on <b>5-27-58</b> Death occurred at <b>9:10p</b> in on the date stated above; and to the best of my knowledge, from the causes stated.		
--	--	--

22a. SIGNATURE <b>K. L. Shirman M.D.</b> (Degree or title)	22b. ADDRESS <b>4606 St John KE Mo</b>	22c. DATE SIGNED <b>5-28-58</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/29/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>Earp &amp; Sons</b>	ADDRESS <b>4707 Truman Rd. K.C.Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-28-58</b>	26. REGISTRAR'S SIGNATURE <b>neva Minshel</b>
--	---	--	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

K. L. Shirman

300  
1-57

2

8

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *William H. Earp* .....

Licensed Embalmer No. *4728* .....

P. O. Address *W.C. Ma* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.