Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012092
STATE FILE NUMBER

FILED MAR 24 1959

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 44

1. PLACE OF DEATH
a. COUNTY: Vernon
b. CITY OR TOWN: Nevada — Inside Limits: Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): State Hospital #3 — Length of stay in it: 35 yrs 5 mo 6 d

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Dade
c. CITY OR TOWN: Everton 0290 — Inside Limits: Yes ☑ No ☑
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☑ No ☐

3. NAME OF DECEASED (Type or print): First: John Middle: M. Last: Kirby

4. DATE OF DEATH: Month: March Day: 9 Year: 1959

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 17, 1887

9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months: 4 Days: 20 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John T. Kirby

13b. MOTHER'S MAIDEN NAME: Minnie Langford

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Hospital records — Address: Nevada, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Bronchial-Acute — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Gen-Arterio Sclerosis
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Psychosis 4500

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March 1, 1956 to March 9, 1959 and last saw ~~her~~ him alive on March 9, 1959
Death occurred at 8:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): W. C. Bradley MD

22b. ADDRESS: State Hospital #3 Nevada Mo

22c. DATE SIGNED: 3-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 3/10/59

23c. NAME OF CEMETERY OR CREMATORY: Greenfield, Mo.

23d. LOCATION (City, town, or county) (State): Greenfield, Mo.

24. FUNERAL DIRECTOR ADDRESS: Canada Funeral Home, Greenfield, Mo.

25. DATE RECD. BY LOCAL REG.: 3-21-1959

26. REGISTRAR'S SIGNATURE: Anna E Fury

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Lloyd C McCall

Licensed Embalmer No. 4853

P. O. Address Moberly, Mo.

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.