

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031290

STATE FILE NUMBER

FILED VS SEP 9 1959
 Registration District No. 1850 360

6225

Registrar's No. 145

INDEXED

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|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington Township</u> | | Length of stay in 1b <u>3 mo 24 day</u> | | c. CITY OR TOWN <u>Joplin</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 3</u> | | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>unknown</u> | |
| 3. NAME OF DECEASED (Type or print) <u>BERTIE KIRTLEY</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1959</u> | | | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-28-1871</u> | 9. AGE (last birthday) <u>88</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DANCE INSTRUCTOR</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DANCE SCHOOL</u> | | 11. BIRTHPLACE (City and state or country) <u>LIVINGSTON CTY, MO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. G.</u> |
| 13a. FATHER'S NAME <u>EUPHRONUS KIRTLEY</u> | | | 13b. MOTHER'S MAIDEN NAME <u>MARTHA STUCKEY</u> | | | 14. NAME OF HUSBAND OR WIFE <u>single</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>unk.</u> | | 17. INFORMANT <u>Hospital records.</u> | | Address _____ |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chor. Brain Syndrome - Senility</u> | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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.) <u>none</u> | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | Month, Day, Year | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 | | COUNTY | STATE |
| 21. I attended the deceased from <u>5/4/59</u> to <u>8/28/59</u> and last saw her alive on <u>8/28/59</u> Death occurred at <u>6:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>George Osher, M.D.</u> (Legible or title) | | | | 22b. ADDRESS <u>State Hospital No 3.</u> | | 22c. DATE SIGNED <u>8/28/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>9-1-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MOORESVILLE CEMETERY,</u> | | 23d. LOCATION (City, town, or county) (State) <u>MOORESVILLE, MISSOURI</u> | | | |
| 24. FUNERAL DIRECTOR <u>STEVE PARKER MORTUARY, JOPLIN, MO.</u> | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. <u>9-3-1959</u> | 26. REGISTRAR'S SIGNATURE <u>Anna E Perry</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1950 01 25

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.