

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032017

**FILED VS. SEP 28 1959**

128

Registration District No. \_\_\_\_\_ Primary Registration District No. 2000

Registrar's No. 987

STATE FILE NUMBER

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield Mo.</u> Length of stay in 1b <u>4 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1100E Locust St.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1100E Locust</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Burton</u> Last <u>Kirby</u>			<b>4. DATE OF DEATH</b> Month <u>Sept</u> Day <u>18</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 24 1883</u>	<b>9. AGE (last birthday)</b> <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u> Hours <u>    </u> Min. <u>    </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Laborer</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Kansas</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>usa</u>		<b>13a. FATHER'S NAME</b> <u>R. P. Kirby</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Susan Henderson</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> _____		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> Address <u>Rose Hampton 942 State, Springfield Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <u>9-18-59 Only</u> <b>and last saw her</b> <u>him</u> <b>alive on</b> _____ <b>Death occurred at</b> <u>9-18-59</u> <b>m on the date stated above, and to the best of my knowledge, from the causes stated.</b>							
<b>22a. SIGNATURE</b> <u>Paul C. Norton M.D.</u> (Degree or title)			<b>22b. ADDRESS</b> <u>1630 N. Jefferson, Spfg., Mo.</u>		<b>22c. DATE SIGNED</b> <u>9-21-59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>Sept 20 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Garrison</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Christian Co. Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Allison Fun</u>		<b>ADDRESS</b> <u>eral Home Greenfield Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-24-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Effie S. Melton</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.