

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dade	
b. CITY (If outside corporate limits, give TOWNSHIP only) Carthage		Length of stay in 1b 3 weeks	c. CITY OR TOWN Greenfield
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Commercial Hotel
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First James Middle Walter Last Kirby, Sr.			4. DATE OF DEATH Month Jan. Day 28, Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Dade County, Mo.	12. CITIZEN OF WHAT COUNTRY U. S. A.	

13a. FATHER'S NAME John Theodore Kirby		13b. MOTHER'S MAIDEN NAME Selia Minerva Langford		14. NAME OF HUSBAND OR WIFE Mary Rosanna Kirby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James W. Kirby, Jr.; Carthage, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 2 days
IMMEDIATE CAUSE (a) Cerebral thrombosis			
DUE TO (b) Arteriosclerosis			
DUE TO (c)			unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Auricular fibrillation			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.)
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		

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 _____
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21. I attended the deceased from **1-17-60** to **1-28-60** and last saw ~~him~~ ^{her} alive on **1-28-60**
Death occurred at **2:05** **p.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deed or title) Shoun Patterson MD		22b. ADDRESS 510 S Main, Carthage, Mo		22c. DATE SIGNED 2-1-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 31, 1960	23c. NAME OF CEMETERY OR CREMATORY Greenfield Cem.	23d. LOCATION (City, town, or county) (State) Greenfield, Mo.	

24. FUNERAL DIRECTOR J. C. Canada, Greenfield, Mo.	25. DATE RECD. BY LOCAL REG. 2-4-60	26. REGISTRAR'S SIGNATURE W. H. Blunt
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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

J. C. Canada

Licensed Embalmer No. *4196*

P. O. Address *Greenfield, Vt.*

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.