

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018341

FILED VS MAY 23 1960 38

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 294

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Randolph</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>Moberly</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>Univ. of Mo. Med. Cen</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>330 E. Burkhardt</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>MIRKMAN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-12</u>	9. AGE (last birthday) <u>47</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>PILE DRIVER FIREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Goodland, Kansas</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Fred L. Kirkman</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Hager</u>			14. NAME OF HUSBAND OR WIFE <u>BONNIE MIRKMAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or <u>unknown</u>)			16. SOCIAL SECURITY NO. <u>494-09-3465</u>		17. INFORMANT Address <u>Hospital chart</u>			
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>ANOXIA, CEREBRAL</u> DUE TO (b) <u>BRAIN ABSCESS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>5 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PNEUMONITIS</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 checked="" type="checkbox"/> NO <input 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 _____ 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>MAY 6, 1960</u> to <u>MAY 16, 1960</u> and last saw her/him alive on <u>MAY 16, 1960</u> Death occurred at <u>3:05 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Waver P. Sights Jr. M.D.</u>				22b. ADDRESS <u>609 Stashin Road</u>			22c. DATE SIGNED <u>MAY 16, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/18/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Garden</u>		23d. LOCATION (City, town, or county) <u>Moberly Mo</u>		(State)	
24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>May 16, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 3 1960

STATEMENT BY LICENSED EMBALMER

MAY 25 1960

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

George D. [Signature]

Licensed Embalmer No. 4425

P. O. Address Columbia

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.