

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-048515

FILED VS DEC 23 1960

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 229 STATE FILE NUMBER

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>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in 1b <u>45 min.</u>	c. CITY OR TOWN <u>Nevada</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada City Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt #2 - two mi. E.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>C.</u> Last <u>Kirby</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1960</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1874</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Abram Carr</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda Stanley</u>	14. NAME OF HUSBAND OR WIFE <u>Dr. Benjamin B. Kirby</u> <small>dec'd 1954</small>
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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>None</u>	17. INFORMANT <u>Mrs. Lillian Welch, Nevada, Mo.</u> Address <u>Rt. #2</u>
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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 <u>3 hrs.</u>
IMMEDIATE CAUSE (a) <u>Fractured skull</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)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Fell down basement steps at home</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ <u>Nov. 28, 1960</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>At home</u>	20f. CITY, TOWN, OR LOCATION <u>Nevada,</u>	COUNTY <u>Vernon,</u>	STATE <u>Missouri</u>
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21. I attended the deceased from November 28, 1960 to Nov. 28, 1960 and last saw her ^{her} alive on Nov. 28, 1960
Death occurred at Nevada, Mo. 8:32 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. P. McCann, M.D.</u>	22b. ADDRESS <u>Moore Bldg., Nevada, Missouri</u>	22c. DATE SIGNED <u>12/2/'60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 30, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Greenfield, Mo.</u>
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24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-16-1960</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Jurey</u>
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(Licensed Embalmer's Statement on Reverse Side)

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,

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.