

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020114

STATE FILE NUMBER

AMENDED

Registration District No. 338 Primary Registration District No. 6148 Registrar's No. 9

FILED MAY 23 1961

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Stoddard | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Castor | | c. CITY OR TOWN Bloomfield | |
| Length of stay in 1b Yrs. | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At family home | | d. STREET ADDRESS (If outside, give location) Route # 3 | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | |
|---|----------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First MENERVIA Middle -- Last KIRBY | | | 4. DATE OF DEATH Month May Day 10 , Year 1961 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-25-1891 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY ---- | | 11. BIRTHPLACE (City and state or country) Shawneetown, Ill. | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | |
| 14. NAME OF HUSBAND OR WIFE Wright Kirby | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---- | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT John Kirby, Bloomfield, Mo. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute circulatory failure DUE TO (b) Myocardial infarction DUE TO (c) atherosclerosis (Coronary artery) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Hypertension | | INTERVAL BETWEEN ONSET AND DEATH acute 1 year Chronic. | |

| | | | | | |
|--|--|---|--|---|--|
| 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.) none | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 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 | | 20g. COUNTY | | 20h. STATE | |

21. I attended the deceased from March 22, 1960 and last saw her alive on May 10, 1961
Death occurred at 11:45 p. m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | | |
|---|--|--|--|--|--|
| 22a. SIGNATURE William J. Trezza, D.O. | | 22b. ADDRESS Bloomfield Mo. | | 22c. DATE SIGNED 5-11-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 13, 61 | | 23c. NAME OF CEMETERY OR CREMATORY Walker cemetery | |
| 23d. LOCATION (City, town, or county) Stoddard co. Missouri | | 24. FUNERAL DIRECTOR CHILES UND. CO. BLOOMFIELD, MO. | | 25. DATE RECD. BY LOCAL REG. 5-18-61 | |
| 26. REGISTRAR'S SIGNATURE Tom. George L. Baker | | | | | |

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James C. Cooper*

Licensed Embalmer No. _____

P. O. Address _____

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.