

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044821

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **6608**

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 10 days	c. CITY OR TOWN Independence
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2303 S. Crescent
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First George Middle Robert Last Kirk	4. DATE OF DEATH Month December Day 31 Year 1961
--------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------

5. SEX male	6. COLOR OR RACE caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1876	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
--------------------	-----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------	----------------------------------	-------------------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher	10b. KIND OF BUSINESS OR INDUSTRY K. C. Schools	11. BIRTHPLACE (City and state or country) Henry County, Mo.	12. CITIZEN OF WHAT COUNTRY USA
----------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------	------------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Matthew Kirk	13b. MOTHER'S MAIDEN NAME Mary Jones	14. NAME OF HUSBAND OR WIFE Josie L. Kirk
-------------------------------------------	------------------------------------------------	-----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Address Alice Gray 2303 S. Crescent Indep., 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) Hypostatic Pneumonia DUE TO (b) Uremia DUE TO (c) Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 weeks 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I (a)) Arteriosclerotic Cardio-Vasc. Dis.		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 9:30 a.m. p.m.	Month, Day, Year
---------------------------------------------------	------------------

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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
-------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from **Dec 1960** to **Dec 31, 1961** and last saw him alive on **Dec 30, 1961**
Death occurred at **9:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. A. Eshelman M.D.	22b. ADDRESS 9306 E New 40 Highway Independence, Mo.	22c. DATE SIGNED Jan 1, 1962
----------------------------------------------------------------	-------------------------------------------------------------	----------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/3/62	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
------------------------------------------------------------	----------------------------	------------------------------------------------------------------	-------------------------------------------------------------------------------

24. FUNERAL DIRECTOR ADDRESS Earp & Sons 4707 Truman Rd. K.C., Mo.	25. DATE RECD. BY LOCAL REG. 1-2-62	26. REGISTRAR'S SIGNATURE Ruth Long
----------------------------------------------------------------------------------	-----------------------------------------------	-----------------------------------------------

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

A. A. Eshelman

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 W. Corp
Licensed Embalmer No. 4622

P. O. Address K. C., Mo.

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.