

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=62-006556**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1042 STATE FILE NUMBER

AMENDED

**FILED MAR 7 1962**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 Max S. Allen

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>20 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>223 W. 62nd Terrace</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>223 W. 62nd Terrace</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>D.</b> Last <b>Irland</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>19,</b> Year <b>1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1879</b>
9. AGE (last birthday) <b>82</b>		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) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Danville, Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>James M. Irland</b>	
13b. MOTHER'S MAIDEN NAME <b>Lucy Maxwell</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Irland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. I</b>	17. INFORMANT <b>Mary Irland, 223 W. 62nd Terr., K. C., Mo</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
DUE TO (b) <b>Cerebral atherosclerosis</b>			<b>10 yrs.</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) <b>T. U. R. For Benign Prostate Hypertrophy Jan 30, 1962 (year)</b>			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 _____ 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 <b>Jan. 1959</b> to <b>FEB 19, 1962</b> and last saw her/him alive on <b>FEB 10, 1962</b> Death occurred at <b>4:15 P. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Max S. Allen</i> (name or title)		22b. ADDRESS <b>K-U Medical Center, K.C., Mo</b>	22c. DATE SIGNED <b>2-20-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-21-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-21-62</b>	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

**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 Orville Robinson

Licensed Embalmer No. 4232

P. O. Address W.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.

*Will say again: see...*