

FILED MAR 18 1944

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1104

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution: J. C. Tuberculosis Hospital
(d) Length of stay: In hospital or institution Apr. 9th to 27th days
In this community 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Rural
(d) Street No. County Poor Farm
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME IKE PIRTLE

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, maried
6. (b) Name of husband or wife Maude Pirtle 6. (c) Age of husband or wife if alive 24 years
7. Birth date of deceased Jan. 24 1884

8. AGE: Years 60 Months 1 Days 17 If less than one day hr. min.

9. Birthplace Arkansas

10. Usual occupation Clayton Operator

11. Industry or business

12. Name Ike Pirtle
13. Birthplace Arkansas
14. Maiden name Dushman
15. Birthplace Arkansas

16. (a) Informant Patent

(b) Address St. C. Tuberculosis Hospital

17. (a) Removal (b) Date thereof 3/10/44

(c) Place: burial or cremation Mena Ark

18. (a) Signature of funeral director J. W. Mayberry

(b) Address San at Olive
19. (a) 3-9-44 (b) H. E. Brown

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8 year 1944 hour 7 minute - P. M.

21. I hereby certify that I attended the deceased from 1-10-43 to 3-8-44
that I last saw him alive on 3-8-44

and that death occurred on the date and hour stated above.
Immediate cause of death Pulmonary T.B. Duration 5 yrs.

Due to

Due to

Other conditions T.B. of spine and left ankle
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 17/8

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature M. J. Brown (M. D. or other) Address J. C. T.B. Hospital Date signed 3-9-44

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Ray E Snow

Licensed Embalmer No. *25620*

P. O. Address *K.C.M.*

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 this body is not embalmed, fact should be so stated above.