

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22385**

Registrar's No. **2826**

BIRTH NO. _____		REG. DIST. NO. <b>149</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. <b>2826</b>	
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> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Kansas City</b> )		c. LENGTH OF STAY (in this place) <b>79 yr</b>		c. CITY OR TOWN <b>Kansas City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Cresthaven Nursing Home</b>				4b. STREET ADDRESS (If rural, give location) <b>46 3516 Summit</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>GRACE</b>		b. (Middle) <b>C</b>		c. (Last) <b>SHIRK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 2 55</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 2</b>		8. DATE OF BIRTH <b>Feb 26, 1868</b>	
9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas 1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>William A. Carmany</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Emmert</b>		14. NAME OF HUSBAND OR WIFE <b>Walter B. Shirk</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Robert Shirk 1915 Glendale Road</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis</b>				<b>5 days</b>	
		ANTECEDENT CAUSES DUE TO (b) <b>arteriosclerosis</b>				<b>unknown</b>	
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>4201</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>June 26, 1955</b> , to <b>July 2, 1955</b> , that I last saw the deceased alive on <b>June 26, 1955</b> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <b>A. L. Spafford</b> A. L. Spafford (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>1414 Professional Bldg Kansas City Mo</b>		23c. DATE SIGNED <b>7/2/55</b>	
24a. BURIAL CREMATION (REMOVAL) (Specify) <b>Burial</b>		24b. DATE <b>July 5, 55</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Sedalia, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>7-3-55</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Stine &amp; McClure Kansas City, Mo</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Allen Spafford  
1414 Prof Bldg

Vi 4425

until 230

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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 ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *J. Crowell*

Licensed Embalmer No. *49*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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