MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5524

1. PLACE OF DEATH.
County Newton — Registration District No. 611 — File No.
Township — Primary Registration District No. 4365 — Registered No.
City Seneca (No. ..... St. ..... Ward)

2. FULL NAME Frank Kirkbride
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Red
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 16 - 1864

7. AGE: Years 62 — Months 4 — Days 20 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED None
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Seneca, ~~Mo~~ Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Edward Kirkbride
11. BIRTHPLACE OF FATHER (CITY OR TOWN) K.Y.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Carrie Driver
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Carrie Lofland
(Address) Seneca Mo

15. FILED 1/10 1927 C. E. Norris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/6 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-4, 1927, to 2-6, 1927 that I last saw him alive on 2-6, 1927, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Haemorrhage
E.R.
(duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (SECONDARY) [illegible]
(duration) ..... yrs. ..... mos. ..... ds

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) [illegible], M. D.
, 19 (Address) Seneca

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lofland Cemetery — DATE OF BURIAL: 2/7 1927

20. UNDERTAKER: Norman E. Mitchey — ADDRESS: Seneca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town an

Length of residence in city or town where death occurred .. yrs. mos. ds. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____hrs. or ____min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended deceased fro
....., 19....., to .....
that I last saw h..... alive on....., 19
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, HOMICIDAL. (See reverse side for additional space.)

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