

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

Do not use this space.

1592

1. PLACE OF DEATH

County J. P. Morgan Registration District No. 420
Township Wattie Primary Registration District No. 5374
City..... (No.....)..... Ward.....

File No.....
Registered No. 9
St..... Ward.....

2. FULL NAME

Wesley Elmer Kirkpatrick
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wesley Elmer Kirkpatrick
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18 1889
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Circuit Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Washington Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bell Grade Mo
(STATE OR COUNTRY)

10. NAME OF FATHER James
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bell Grade Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Shipton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bell
(STATE OR COUNTRY)

14. INFORMANT Mrs W. E. Kirkpatrick
(Address) Refugio Mo

15. FILED 1/23 1928 D. L. Ruggley
(REGISTRAR)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 22 1928
17. I HEREBY CERTIFY, That I attended deceased from Jan. 21 1928 to Jan. 22 1928
that I last saw him alive on Jan. 22 1928, and that death occurred, on the date stated above at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Appendicitis
121 B (duration) yrs. mos. 2 da.
CONTRIBUTORY (SECONDARY) 117 B (duration) yrs. mos. da.

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) Joseph L. Thurman M. D.
1/22 1928 (Address) Refugio, Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Refugio DATE OF BURIAL Jan 24 1928

20. UNDERTAKER Chas. B. Bannock ADDRESS Refugio Mo

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.

FADING INK—THIS IS A PERMANENT RECORD

38-7-14

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SHALL NOT RECEIVE A FILE FOR CERTAIN INFORMATION AND COMPANY AS PRESERVE

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

Should state
if important.

C O P I E D B Y L A W

1. PLACE OF DEATH.

County Jefferson
Township ..
City .. (No., St. Ward)

Registration District No. 420
Primary Registration District No. 557F

File No.
Registered No. 9

2. FULL NAME

Wesley Elmer Kirkpatrick

(a) Residence. No. St. Ward.
(Usual place of abode) (If non-resident 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 M 4. COLOR OR RACE M 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 8-1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 00 14

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)

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 3/9 1914 D. L. Raupp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 1920

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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)....., M. D.

, 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

ES

O F V L

REGISTRARS S

N. B.—Eye
CAUSE O.

SUPPLEMENTARY

S-189A