

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

35994

Do not use this space:

9571

1. PLACE OF BIRTH **NOV 15 1937**

(a) County ..... Registration District No. **791**

(b) Township ..... Primary Registration District No. **1003**

(c) **St. Louis, Missouri** (a) Street No. **City Hospital No. 1** St. (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

C. 8037

2. PRINT FULL NAME **Harriett Kirkpatrick**

(a) Residence, No. **3649 Vista** St. **18** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **female**

4. COLOR OR RACE **white**

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) **None**

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<b>77</b>	<b>-</b>	<b>-</b>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**

9. Industry or business in which work was done, as saw mill, bank, etc. **8**

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

FATHER

13. NAME **Charles Kirkpatrick**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **England**

MOTHER

15. MAIDEN NAME **Harriett Clark**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **England**

17. INFORMANT **Hosp. Info M. Kent**  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **Oak Grove Cem** DATE **Oct 15 1937**

19. FUNERAL DIRECTOR **Fred M. Williams**  
(ADDRESS) **4521 24th St. St. Louis**

20. FILED **OCT 14 1937** **J. B. Bledsoe**  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/13/37** 19

22. I HEREBY CERTIFY, That I attended deceased from **9/4/37**, 19, to **10/13/37**, 19.

I last saw her alive on **10/13/37**, 19. Death is said to have occurred on the date stated above, at **3. a.** m.

The principal cause of death and related causes of importance were as follows:

**Brachopneumonia**  
**Senile Dementia**

Date of onset

Other contributory causes of importance: **107**

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify **Chas. M. Jessner!** M. D.  
(Address) **City Hospital No. 1**

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

1 X12004

PHOTO COPY  
EXACTLY

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

**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.)**