

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15581

MAY 15 1940  
Registration District No. 821

Primary Registration District No. 5801

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural - East  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 years (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Frank Cherry Kirkpatrick

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose Kirkpatrick 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased 3 9 1889  
(Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saltillo Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name E. B. Kirkpatrick

13. Birthplace Saltillo Miss.  
(City, town, or county) (State or foreign country)

14. Maiden name Maggie Cherry

15. Birthplace Saltillo Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Kirkpatrick

(b) Address Matthews Ho.

17. (a) Burial (b) Date thereof 4/21/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Saltillo Miss.

18. (a) Signature of funeral director Hunter Albritton

(b) Address Sikeston

19. (a) 2-9-1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Rural - East  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 20  
year 40 hour 1:30 minute A M.

21. I hereby certify that I attended the deceased from 4-20-19  
1940 to 4-20 1940  
that I last saw him live on 4-19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic  
Cardiac Valvular  
Disease Duration 3 yrs.

Due to \_\_\_\_\_  
Due to 92.9

Other conditions Alcoholism 5 days  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 5-20

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

23. Signature Thomas C. McClave, Jr. (M.D. or other)

Address Sikeston, Mo. Date signed 4-20

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.

RECEIVED

District Health Officer No. 2,

District File Number 540-102

Date Filed 5/14/40

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**