

Registration District No. 318

Primary Registration District No. 5439

Registrar's No.

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hr. and 50M
(Specify whether)
In this community Life time.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. Route 10.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Loyal & Clara Kirkpatrick

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 27, 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 3 hr. 50 min.

9. Birthplace Springfield, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Inf.

11. Industry or business _____

12. Name Loyal Kirkpatrick

13. Birthplace Moberley Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Clara Buckner

15. Birthplace Cherryvale Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Kirkpatrick

(b) Address Rt. 10 Springfield.

17. (a) Burial (b) Date thereof 9-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield

19. (a) 9-27-1940 (b) W.E. Naudlym
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1940 hour 6 minute 50 A.M.

21: I hereby certify that I attended the deceased from 9/26/40
_____, 19____, to _____, 19____;

that I last saw him alive on 9/26/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth (7mo)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 5 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. Adair (M. D. or other) thos.

Address Springfield Mo Date signed 9/27/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.