

36517

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ED NOV 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott County

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sikeston General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one hour
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Matthews Mo. Rural
(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.

3. (a) PRINT FULL NAME Charles Kirkpatrick

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 5 20 1905
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

| | | | | |
|-----------|----------|----------|-----|------|
| Years | Months | Days | hr. | min. |
| <u>35</u> | <u>5</u> | <u>8</u> | | |

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name C. 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 Rose Kirkpatrick

(b) Address Matthews Mo. R.F.D.

17. (a) Burial (b) Date thereof 10/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Saltillo Miss.

18. (a) Signature of funeral director John Albritton

(b) Address Sikeston Mo.

19. (a) 11-6-1940 (b) W. H. Presnell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 28
year 1940 hour 8 minute 15 P. M.

21. I hereby certify that I attended the deceased from 10-28
1940 to 10-28 1940

that I last saw him alive on 10-28-1940
and that death occurred on the date and hour stated above.

Immediate cause of death Multiple fracture of skull = Chamber fracture left thigh. Due to leg; Fracture left elbow. Fracture of ribs on left. Due to right from 1st to 8th

Duration _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Auto accident

(b) Date of occurrence 10-28-1940

(c) Where did injury occur? New Madrid Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Road

While at work Yes (Specify type of place) Street Collision

(e) Means of injury _____

23. Signature Thomas C. McClure (M. D. or other) _____

Address Sikeston, Mo. Date signed 10-29-40

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

Rev. 6-17-39 I 19151

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.

2.10 m

RECEIVED

District Health Officer No. 2

District File Number 1140-1659

Date Filed 11/7/40

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 John Albritton

Licensed Embalmer No. 2941

P. O. Address Dickinson, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36579
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 821

Primary Registration District No. 4553

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

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Dikeston
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Chas. Kirkpatrick

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 35 Months 2 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 10 day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Multiple fracture of skull - compound fracture of left leg.
Due to Collision of two trucks

Due to on highway # 61 at Matthews, Mo. intersection

(Other conditions _____)
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 10-28-1940

(c) Where did injury occur? Matthews, Mo. Co. near
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Public Rd. Crossing

While at work? yes (Specify type of place) Collision of trucks
(e) Means of injury

23. Signat. Thomas C. McClure (M. D. or other)

Address Dikeston, Mo. Date signed 12-18-40

SUPPLEMENTAL

