No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12366

Registration District No. FILED MAY 7 1943 318

Primary Registration District No. 1003

Registrar's No. 4023

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

1. PLACE OF DEATH:

(a) County St. Louis St. Louis

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

(c) Name of hospital or institution: Masonic Home of Missouri 5 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 5 Mos. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 17

(c) City or town St. Louis 7/2 (If outside city or town limits, write "RURAL")

(d) Street No. 5351 Delmar Boulevard (If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Lottie Kilpatrick

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex F

5. Color or race W 1

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife

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

7. Birth date of deceased December 16, 1872 (Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 13 If less than one day hr. min.

9. Birthplace St. Louis, Missouri (City, town, or county) 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Andrew S. McBride
13. Birthplace Delaware (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Martha L. Julian
15. Birthplace Sante Fe, Tennessee (City, town, or county) 1 (State or foreign country)

16. (a) Informant Iva Hirsch

(b) Address 5351 Delmar, St. Louis

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/29/43 (Month) (Day) (Year)

(c) Place: burial or cremation Houston, Texas

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd.

19. (a) APR 29 1943 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29, year 1943 hour I. 20 minute A. M. M.

21. I hereby certify that I attended the deceased from December 3, 1940, 19, to April 29, 43, 19; that I last saw her alive on April 28, 1943, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Hypertension	3 yrs.
Due to:	
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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 5687 N. Grand Blvd. Date signed 4-29-43

(Licensed Embalmer's Statement on Reverse Side)

4023

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 Albert E. Kopp

Licensed Embalmer No. 2971

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, fact should be so stated above.

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12366

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4023

1. PLACE OF DEATH:

(a) County S

(b) City or town St Louis
(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 years, months or days)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lottie Kilpatrick

3. (b) If veteran, name war

3. (c) Social Security No. Widowed

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife — —

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

7. Birth date of deceased Dec 16 1872
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) JUN 28 1943 (Date received local registrar) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1943 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
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.

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY