

FILED DEC 23 1943

Registration District No. 279

Primary Registration District No. 62934549

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant City, Mo
(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 75 years..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Grant City Mo
(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 Charles Sumner Kirkpatrick
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1943, hour 8^{PM} minute 30^P M.

21. I hereby certify that I attended the deceased from ADV-28
..... 1943 to 12-2-1943..... 1943

that I last saw him alive on 12-3-1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction of heart
Due to.....
Due to.....

Duration 2 hrs

Other conditions (Include pregnancy within 3 months of death) 928
Major findings: Of operations
Of autopsy no

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?

While at work? no (Specify type of place) (e) Means of injury.....
23. Signature W. H. Kead (M.D. or other)
Address Grant City Mo Date signed 12-4-43

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Zadie Cornelia Kirkpatrick 6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased 10-3-1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 2 0 hr. min.

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

10. Usual occupation day laborer

11. Industry or business.....

12. Name John Kirkpatrick

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

14. Maiden name Elizabeth Orr

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

16. (a) Informant Zadie Kirkpatrick

(b) Address Grant City, Mo.

17. (a) Burial (b) Date thereof 12-5-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant City Cemetery

18. (a) Signature of funeral director W. H. Kead
(b) Address Grant City, Mo.

19. (a) Dec 6-1943 (b) Arlene Scadden
(Date received local registrar) (Registrar's signature)

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.....

Jack C. Dunfee

Licensed Embalmer No.....

3252

P. O. Address.....

Grant city, 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, fact should be so stated above.