

FILED MAR 9 1944  
Registration District No. **0000**

Primary Registration District No. **5256**

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

1. PLACE OF DEATH:

(a) County **Chariton**

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

(c) Name of hospital or institution: **Cummins**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community **Life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Chariton**

(c) City or town **SUMNER**  
(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 **MARY V. KILPATRICK**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **13<sup>th</sup>** year **1944** hour **10** minute **15** P.M.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Robt. B. Kilpatrick** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **OCT 23 1857**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 30 1944** to **Feb 13 1944** that I last saw him alive on **Feb 13** and that death occurred on the date and hour stated above.

8. AGE: Years **86** Months **3** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: **Cerebral hemorrhage**  
**Hypertension**  
Duration **15 days**  
Due to **Brain**

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

10. Usual occupation **Housewife**

Other conditions (Include pregnancy within 3 months of death) **3a**

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

12. Name **George Smith**

13. Birthplace **Virginia** (City, town, or county) (State or foreign country) **1**

14. Maiden name **W. Bly**

15. Birthplace **Virginia** (City, town, or county) (State or foreign country) **1**

Major findings: Of operations **none**

Of autopsy **none**

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Earl Robinson**

(b) Address **277 SUMNER, MO**

17. (a) **Burial** (b) Date thereof **2-16-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lakeside, Sumner**

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? \_\_\_\_\_

18. (a) Signature of funeral director **D. S. Shepard**

(b) Address **Mendon Mo**

19. (a) **Feb 15 1944** (b) **Martha Clark**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (City or place) (e) Means of injury **0**

23. Signature **J. A. Lewis** (M. D. or other **MD**)  
Address **Sumner Mo** Date signed **2/15/44**

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

21  
0  
0

1355

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-8-44

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.....

working under my personal supervision.

....., Registered Apprentice No. ....

Signed.....

*S. Shepard*

Licensed Embalmer No. ....

3970

P. O. Address.....

*Mendota 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.