. S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 5 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36065

Primary Registration District No. 1003

Registrar's No. 10015

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: St. Louis Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3922 Delor St. (If not in hospital or institution, write street number or location) 1

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

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: 15

(c) City or town: St. Louis Mo (If outside city or town limits, write "RURAL")

(d) Street No.: 3922 Delor St. (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME: MINERVA J. KIRK

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife: George H.

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

7. Birth date of deceased: Dec. (Month) 5 (Day) 1853 (Year)

8. AGE: Years 90 | Months 11 | Days 19 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Housewife

11. Industry or business: —

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

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

16. (a) Informant: Margaret B. La Corte
(b) Address: 3922 Delor St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-27-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Pulico Mo

18. (a) Signature of funeral director: Watkins Service
(b) Address: Pulico Mo

19. (a) NOV 24 1944 (Date received local registrar) J. Redeel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24 year 1944 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Nov. 8, 1944, to Nov. 24, 1944, that I last saw her alive on Nov 23, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	don't know
Due to: Senility	
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: John C. Cornell (M. D. or other) MD

Address: 5005 Gravois Date signed 11-24-44

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 5 1944 318

Registration District No. _____

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36065

Primary Registration District No. 1003

Registrar's No. 100.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis Mo
(c) Name of hospital or institution: 3922 Delor St.
(d) Length of stay: In hospital or institution _____ In this community _____

2. (a) PRINT FULL NAME MINERVA J. KIRK
(b) If veteran, name war _____
3. (a) Social Security No. _____
4. Sex F
5. Color or race W
6. (a) Single, married, widowed, divorced Widow
(b) Name of husband or wife Joseph
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 5 1853 (Month) (Day) (Year)
8. AGE: Years 90 Months 11 Days 19 If less than one day hr. _____ min.
9. Birthplace Eureka Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
MOTHER OF FATHER
12. Name James M. Kirkpatrick
13. Birthplace Iowa Missouri (City, town, or county) (State or foreign country)
14. Maiden name Unknown Delila Sifford
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Margaret B. La Corte
(b) Address 3922 Delor St.
17. (a) Burial (Cremation, entombment, or removal) (b) Date filed 11-27-44 (Month) (Day) (Year)
(c) Place burial or removal Grace Mo
18. (a) Signature of funeral director Joseph Watkins Jr.
(b) Address 1515 N. Grand St. Louis Mo
19. (a) NOV 28 1944 (Date received locally registered) (b) Registrar

7. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis Mo (If outside city limits or town limits, write "RURAL")
(d) Street No. 3922 Delor St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 24 year 1944 hour 8 minute A. M.
21. I hereby certify that I attended the deceased from Nov. 8 1944 to Nov. 24 1944 that I last saw her alive on Nov. 23 1944 and that death occurred on the date and hour stated above.
Immediate cause of death Chronic Myocarditis
Due to Senility
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: (If operation) _____ (If autopsy) _____
Description: Died Home
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)
(e) How injury occurred _____
23. Signature Paul Cornell M.D. (M. D. or other) MD
Address 1515 S. Grand Date signed 11-27-44

(Licensed Embalmer's Statement on Reverse Side)

Items #12, 14 amended by affidavit of Great Grandson 3-16-90