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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25846

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7398

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

1. PLACE OF DEATH:

(a) County

(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:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos-29 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")

(d) Street No. 2909 CALIFORNIA AV. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Minnie Kirkpatrick

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife J. KIRKPATRICK

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

7. Birth date of deceased JULY (Month) 30 (Day) 1872 (Year)

8. AGE: Years 73 Months 0 Days 24 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN.

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

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

16. (a) Informant Mrs E. Schnur
(b) Address 3125 Lafayette av

17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof AUG 25/45 (Month) (Day) (Year)
(c) Place: burial or cremation NEW PICKERS

18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette av

19. (a) AUG 25 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23rd year 1945 hour 6:30 minute P. M.

21. I hereby certify that I attended the deceased from 5/25/45, 19, to 8/24/45, 19; that I last saw her alive on 8/24/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction

Due to Adenocarcinoma of rectum

Due to Recurrence following operation?

Other conditions (Include pregnancy within 3 months of death) 46

Major findings: Of operations Adenocarcinoma of rectum

Of autopsy

Duration

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 Philip F. D. Seitz (M. D. ~~or other~~)

Address 1515 Lafayette Date signed 8/24/45

(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 Jas B Vollmer

Licensed Embalmer No. 4014

P. O. Address Hancock 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.