

S. No. 2
M-5-43
7-5-17-39
I X36671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL RECORDS
FILED NOV 30 1945 STANDARD CERTIFICATE OF DEATH

State File No. 36477
Registrar's No. 30

Registration District No. 1 Primary Registration District No. 3000

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home Center
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months & 10 days
(Specify whether years, months or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Adair
(c) City or town Kirkville
(If outside city or town limits, write "RURAL") 3
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Susan E. Kirkpatrick
3. (b) If veteran, name war ✓
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 21
year 1945 hour 12 minute 15 P.M.
21. I hereby certify that I attended the deceased from July 11
1945 to Oct 21 1945
that I last saw her alive on Oct 21 1945
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Wm R. Kirkpatrick alive _____ years
7. Birth date of deceased: Mar 24 - 1859
(Month) (Day) (Year)

Immediate cause of death: Cerebral hemorrhage Duration 4 hrs
Due to Hypertensive heart disease years
Due to arteriosclerosis years
Other conditions: _____
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
86 6 27 hr. _____ min.

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy 830
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Retired

11. Industry or business Housewife

12. Name Geo. Nichols

13. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Ruby Goodnight

15. Birthplace Pike Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Ray

(b) Address Atlanta Mo

17. (a) Burial (b) Date thereof Oct 23, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Queen city Mo

18. (a) Signature of funeral director Wm Goodnight

(b) Address Atlanta Mo

19. (a) 10-24-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

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? _____ (Specify type of place) (e) Means of injury _____
23. Signature M.T. Gutenshner (M.D. or other) OO
Address Kirkville, Mo. Date signed 10-21-45

1614 (Licensed Embalmer's Statement on Reverse Side)

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

3

RECEIVED

District Health Officer No. 10

District File Number 11-45-1280

Date Filed NOV 27 1945

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.....

Hmsbrading....., Registered Apprentice No.
working under my personal supervision.

Signed Hmsbrading.....

Licensed Embalmer No. 1756.....

P. O. Address Atlanta Ga.....

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.