

No. 2  
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5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED AUG 12 1946

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22558**

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 210

1. PLACE OF DEATH:  
 (a) County Adair  
 (b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
S. Hamilton Street Crossing  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution None 3  
(Specify whether Life)  
 In this community Life  
years, months or days

3. (a) PRINT FULL NAME Delmar Kirkpatrick  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Vera Crist 6. (c) Age of husband or wife if alive 28 years  
 7. Birth date of deceased Oct. 27 1915  
(Month) (Day) (Year)

8. AGE: Years 30 Months 8 Days 13  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Adair Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER { 12. Name Isaac Wm. Kirkpatrick  
 13. Birthplace Mark Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Edna Collier  
 15. Birthplace Mark Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna Kirkpatrick  
 (b) Address Kirksville, Missouri

17. (a) Burial (b) Date thereof 7/22/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Highland Park Cmt.

18. (a) Signature of funeral director B. P. Ruby  
 (b) Address Kirksville, Missouri

19. (a) 7-26-46 (b) Wate Lambert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Adair  
 (c) City or town Kirksville  
(If outside city or town limits, write "RURAL")  
 (d) Street No. R. R. # 5  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 20  
 year 1946 hour 3:05 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Accidentally struck by Wabash Freight Train Number 99 at Hamilton Street crossing, Kirksville, Mo.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

22. If death was due to external cause, list 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? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature F. H. Embury 3 Emory  
(M. D. or other)  
 Address Brushy, Mo. Date signed 7-22-46

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

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

RECEIVED  
District Health Officer No. 90  
District File Number 8-46-1771  
Date Filed - AUG 10 1946

**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..... *SEE Riley* .....

Licensed Embalmer No. *4181* .....

P. O. Address *Pittsfield Mass* .....

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2142  
Registrar's No. 216

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Delmar Kirkpatrick

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Oct 27 (Month) (Day) (Year)

8. AGE: Years 30 Months 8 Days 3 Unless than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 20  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to S.H.P. Truck he was driving was struck  
Due to by a Wabash train  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy NO

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence July 20 1946  
(c) Where did injury occur? Kirkville, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on street crossing

While at work? yes (Specify type of place) (e) Means of injury that struck

23. Signature Frederic R. Early (M. D. or other) \_\_\_\_\_  
Address Brunswick, Mo. Date signed 9-7-46

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

SUPPLEMENTARY

MOTHER FATHER

21422

22558