

FILED SEP 16 1946

Registration District No. 33

Primary Registration District No. 3010

Registrar's No. 300

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU
 (b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST. FRANCIS HOSP O
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 DAYS
(Specify whether years, months or days)
 In this community 5 DAYS
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County BOLLINGER
 (c) City or town GRASSY
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME RUSSEL MARVIN KIRKPATRICK

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

| | | |
|---|---------------------------|--|
| 4. Sex <u>M</u> | 5. Color or race <u>W</u> | 6. (a) Single, widowed, married, divorced <u>MARRIED</u> |
| 6. (b) Name of husband or wife <u>ORA LEE KIRKPATRICK</u> | | 6. (c) Age of husband or wife if alive <u>36</u> years |
| 7. Birth date of deceased <u>APRIL 12 1908</u> <small>(Month) (Day) (Year)</small> | | |

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>38</u> | <u>4</u> | <u>13</u> | hr. _____ min. _____ |

9. Birthplace GRASSY MO. O
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name CHARLES M. KIRKPATRICK
 13. Birthplace BOLLINGER CO. MO.
(City, town, or county) (State or foreign country)
 14. Maiden name MARY E. HILL
 15. Birthplace KANSAS
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ora Lee Kirkpatrick
 (b) Address Grassy Mo

17. (a) BURIAL (b) Date thereof 9-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GRASSY, MO.

18. (a) Signature of funeral director BAKER FUNERAL HOME

(b) Address LUTESVILLE MO.

19. (a) 9-11-1946 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 1 ST
 year 1946 hour 7:00 minute 15 A. M.

21. I hereby certify that I attended the deceased from Jan 1946 to Sept 1 1946
 that I last saw him alive on Aug 31 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism Duration 2 days
 Due to Acute glomerular nephritis 9 mo.
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations none / 11A
 Of autopsy none
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. B. Shaughnessy (M. D. or other) MD
 Address 801a Broadway Date signed 9-11-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 946-2609

Date Filed 9-16-46

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 *J. C. Graham*

Licensed Embalmer No. 4010

P. O. Address *Fayetteville, 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.