

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35307

State File No.

318

1003

9294

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Louis</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Louis</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Faith Hospital, 2800 N. Taylor</u>				d. STREET ADDRESS (If rural, give location) <u>17-4016a McRee</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u>		b. (Middle) <u>Jane</u>		c. (Last) <u>Kirkpatrick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 27 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug 30 1875</u>	
				9. AGE (In years last birthday) <u>74 yrs</u>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>No. Cumberland, England</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Thomas Burns</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Jane Lowes</u>			14. NAME OF HUSBAND OR WIFE <u>Adam Kirkpatrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Adam Kirkpatrick, 4016a McRee</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma Breast (operated 8 months)</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Breast</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE? (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>87</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>170X</u>			
22. I hereby certify that I attended the deceased from <u>4-2, 1949</u> to <u>10-27, 1949</u> , that I last saw the deceased alive on <u>10-27, 1949</u> and that death occurred at <u>10:15 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Joo P. Beriman M.D.</u>			23b. ADDRESS (Degree or title) <u>1225 No. Grand</u>			23c. DATE SIGNED <u>10-28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Oct 31 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Edwardsville, Ill</u>	
DATE REC'D BY LOCAL REG. <u>OCT 29 1949</u>		REGISTRAR'S SIGNATURE <u>J B Laster</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Truth Center Mortuary 4024 Lindell</u>		

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

Ronald O. Yalunka

Signed.....

Student Embalmer

Licensed Embalmer No. *3917*

P. O. Address *St. Louis*

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.