

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12805**
Registrar's No. **375-B**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Springfield
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		No. STREET ADDRESS 657 E. Main (If rural, give location) 2396	
3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) J. c. (Last) Kirkpatrick		4. DATE OF DEATH (Month) (Day) (Year) April 16, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 22, 1883
9. AGE (In years, last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Pittsburg Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Jos Henry Kirkpatrick		13b. MOTHER'S MAIDEN NAME Emeline Alexander	
14. NAME OF HUSBAND OR WIFE Rose J. Kirkpatrick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 497-30-1545		17. INFORMANT'S SIGNATURE OR NAME Mrs Rose J. Kirkpatrick, wife ADDRESS Springfield	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" 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) 3			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 6 , 19 57 , to Apr 16 , 19 57 , that I last saw the deceased alive on April 16 , 19 57 , and that death occurred at 4:45 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE J.P. Massey (Degree or title) MD		23b. ADDRESS Springfield 4, Mo.	
23c. DATE SIGNED 4/20/57			
24a. BURIAL CREMATION REMOVAL (Specify) Burial		24b. DATE Apr. 19-1957	
24c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.	
DATE REC'D BY LOCAL REG. 4-25-57		REGISTRAR'S SIGNATURE Loath. Williamson	
25. FUNERAL DIRECTOR'S SIGNATURE Max L. Fossett		ADDRESS Mo.	

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.

Student.....
Signature of Student Embalmer

Signed *Max L. French* -

Licensed Embalmer No. *4252*

P. O. Address *McW... , Pa*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.