

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 6 1957

State File No. **23938**

BIRTH NO.		REG. DIST. NO. 75		PRIMARY REG. DIST. NO. 3015		Registrar's No. 77	
1. PLACE OF DEATH a. COUNTY Clinton				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). ---a. STATE Mo b. COUNTY Dickinson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cameron		c. LENGTH OF STAY (in this place) 7 days		c. CITY OR TOWN Osborne		d. Is residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF HOSPITAL OR INSTITUTION Cameron Hospital				e. STREET ADDRESS (If rural, give location) 320			
3. NAME OF DECEASED (Type or Print) Doris		a. (First) Fern		c. (Last) Kirkpatrick		4. DATE OF DEATH (Month) (Day) (Year) 7 31 57	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 11-6-1923	
9. AGE (In years last birthday) 33		IF UNDER 1 YEAR Months Days Hours Mins.		11. BIRTHPLACE (City and State or Foreign Country) Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		13a. FATHER'S NAME William McMahill		13b. MOTHER'S MAIDEN NAME Alice Potter	
13c. NAME OF HUSBAND OR WIFE James Kirkpatrick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 500-14-7856		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William McMahill, Osborne Mo.	
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) Chromatoid & tuberculation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinomatous DUE TO (c) Schirous Carcinoma of Breast II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 6 wks 6 mo 9 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? ☒ YES ☐ NO		170X	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-21- , 19 57 , to 7-31- , 19 57 , that I last saw the deceased alive on 7-30- , 19 57 , and that death occurred at 5:15 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) B. H. Compton M.D.		23b. ADDRESS Osborne Mo		23c. DATE SIGNED 8-2-57			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 8-3-57		24c. NAME OF CEMETERY OR CREMATORY Osborne		24d. LOCATION (City, town, or county) (State) Osborne Mo	
DATE REC'D BY LOCAL REG. 8-3-57		REGISTRAR'S SIGNATURE Francis Crawford		25. FUNERAL DIRECTOR'S SIGNATURE John Brown		ADDRESS Maysville Mo	

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.. 3933..

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