

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 22 1959

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Registration District No. 171 Primary Registration District No. 5639 Registrar's No. 57

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>	Length of stay in 1b	c. CITY OR TOWN <u>Mayview</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 mi. N. of Mayview</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JESSIE</u> Middle <u>KIRKPATRICK</u> Last <u>KIRKPATRICK</u>			4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Clair Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>T. A. Sedge</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>A. M. Kirkpatrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>194-14-3522</u>	17. INFORMANT Address <u>A. M. Kirkpatrick Mayview, Missouri</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>Several yrs.</u>
IMMEDIATE CAUSE (a) <u>Myocardial dysfunction</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ASAD</u>		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>been treated for congestive heart failure 3 mo.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Oct. 23, 1959 to Dec 10, 1959 and last saw her alive on Dec. 10, 1959
Death occurred at 8:54 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wilbur E. Kulbersen M.D.</u>	22b. ADDRESS <u>Higginsville Mo.</u>	22c. DATE SIGNED <u>12/11/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 13 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>A. H. Hader Funeral Home</u> <u>By: A. H. Hader Higginsville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12/12/1959</u>	26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold L. Walsh

Licensed Embalmer No. 458

P. O. Address Livingston,

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.