

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 1 1961

61-003295

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **667** STATE FILE NUMBER **61-003295**

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|---|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis | | | Length of stay in lb 17 days | | c. CITY OR TOWN Ellisville | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1370 Clayton Rd. | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lucile Middle May Last Kirkmen | | | | | | 4. DATE OF DEATH Month Jan Day 21 Year 1961 | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 11-9-94 | |
| 9. AGE (last birthday) 66 | | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (City and state or country) Buchanan Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Frank Simpson | | | 13b. MOTHER'S MAIDEN NAME Mary Katherine Speaker | | | 14. NAME OF HUSBAND OR WIFE Guy E. Kirkmen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Guy Kirkmen | | Address Ellisville, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC INSUFFICIENCY DUE TO (b) AORTIC VALVE STENOSIS DUE TO (c) 4211 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 WKS UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 | |
| 21. I attended the deceased from Jan. 5, 1961 to Jan 21, 1961 and last saw her alive on Jan 21, 1961 Death occurred at 4:45 pm Jan 21, 1961 on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Robert E. Coch, M.D. | | | | | 22b. ADDRESS 35 N. Central | | 22c. DATE SIGNED 1-23-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | 23b. DATE 1-24-61 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory | | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | |
| 24. FUNERAL DIRECTOR Schrader Funeral Home Ballwin, Mo. | | | | | 25. DATE RECD. BY LOCAL REG. JAN 23 1961 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |

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 Richard M. Bopp

Licensed Embalmer No. 4584

P. O. Address Ballwin 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.