SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-023503

FILED JUN 16 1961

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1490

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROCK HILL — Length of stay in 1b MONS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ROCK HILL REST HOME — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY
c. CITY OR TOWN ST LOUIS — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 6042 POINT VIEW — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First RILEY Middle F Last KIRKPATRICK

4. DATE OF DEATH Month MAY Day 26 Year 1961

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH MAY 25 1873

9. AGE (last birthday) 88 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY ——

11. BIRTHPLACE (City and state or country) ARKANSAS

12. CITIZEN OF WHAT COUNTRY U-S-A

13a. FATHER'S NAME JOHN KIRKPATRICK

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE ALICE B. 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.

17. INFORMANT ALICE KIRKPATRICK Address 6042 POINT VIEW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) generalize arteriosclerosis
DUE TO (c) 4
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 11-14-60 and last saw him alive on 5-22-61
Death occurred at 12 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. L. Merklin M.D.

22b. ADDRESS 3507 Potomac

22c. DATE SIGNED 5-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE MAY 29 1961

23c. NAME OF CEMETERY OR CREMATORY NEW ST MARCUS CEM

23d. LOCATION (City, town, or county) ST LOUIS Co. (State) MO.

24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. 5-27-61

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

PRI-1863

at 2 P.M. Friday

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 _____ Signed Eleuan Provinee

Signature of Student Embalmer

Licensed Embalmer No. 3403

P.O. Address 2906 Grova

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.