

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8979

1. PLACE OF DEATH

County Cooper Registration District No. 224
Township Prairie Home Primary Registration District No. 4137
City (No. _____) _____ St. _____ Ward _____

File No. _____
Registered No. 4

2. FULL NAME Robt. Franklin Kirkpatrick

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 30 - 1850</u>			
7. AGE	YEARS <u>82</u>	MONTHS <u>5</u>	DAYS <u>19</u>
	If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work <u>Retired</u>			
(b) General nature of industry, business, or establishment in which employed (or employer) _____			
(c) Name of employer _____			
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 19 1933

17. I HEREBY CERTIFY, That I attended deceased from Jan 1932 to 3 - 19 1933 that I last saw him alive on 3 - 11 1933, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Chronic Bronchitis
as then a now
Subacute
106 lbs (duration) unknown yrs. mos. da.

CONTRIBUTORY (SECONDARY) 23 (duration) _____ yrs. mos. da.

PARENTS	10. NAME OF FATHER <u>Wm. Preston Kirkpatrick</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>
	12. MAIDEN NAME OF MOTHER <u>Coe</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>
14. INFORMANT (Address) <u>Noland Kirkpatrick</u>	
15. FILED <u>3-20</u> <u>A. K. Wendt</u> REGISTRAR	

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) A. K. Wendt, M. D.
3-20-33 (Address) Prairie Home Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Englewood Cem. Clinton</u>	DATE OF BURIAL <u>3/21 1933</u>
20. UNDERTAKER <u>C. Albert Hornbeck</u>	ADDRESS <u>Prairie Home</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 22 1933

