

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

Do not use this space.

34800

1. PLACE OF DEATH

County Ray
Township Richmond
City Richmond (No. _____)

Registration District No. 744
Primary Registration District No. 3035

File No. _____
Registered No. 85
St. _____ Ward _____

2. FULL NAME

Hettie F. Kirkpatrick

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb. 1 - 1887

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

76

9

18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Akron

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

L. D. Clark

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Akron

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Virginia Johns

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Akron

(STATE OR COUNTRY)

Ohio

14.

INFORMANT (Address)

Marietta Kirkpatrick
Richmond, Mo.

15.

FILED

1929

Oct 31

6.6

Lay

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct - 19 19 29

17.

I HEREBY CERTIFY, That I attended deceased from 10-2, 1929, to 10-19, 1929, that I last saw him alive on 10-19, 1929, and that death occurred, on the date stated above, at 9-30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Bronchial Pneumonia

(duration) 10 yrs. 2 mo. 2 da.

CONTRIBUTORY (SECONDARY)

apoplexy

(duration) _____ yrs. _____ mo. 17 da.

18. WHERE WAS DISEASE CONTRACTED

IS NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Geo. F. Koon M. D.

10-21-1929 (Address) Richmond 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

Delphi Ind.

DATE OF BURIAL

Oct 22, 1929

20. UNDERTAKER

E. Thurman

ADDRESS

Richmond

X. 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.

89
66
f

23
2

