

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **8104**  
Registrar's No. **399**

FILED APR 16 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 9yrs	
c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) 1405 Penn Street <i>0110</i>	
3. NAME OF DECEASED (Type or Print) Lloyd		a. (First) Lloyd b. (Middle) D. c. (Last) Gilpatrick	
4. DATE OF DEATH (Month) (Day) (Year) April 5 1956			
5. SEX male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH July 18, 1923	
9. AGE (In years last birthday) 32		IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hudson Oil Co	
11. BIRTHPLACE (City and State or Foreign Country) Ridgeway, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edgar Gilpatrick		13b. MOTHER'S MAIDEN NAME Cecil Hontz	
14. NAME OF HUSBAND OR WIFE Dorothy May Gilpatrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. 498-24-7616	
17. INFORMANT'S SIGNATURE OR NAME Dorothy May Gilpatrick		ADDRESS Missouri St. Joseph	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sub acute bacterial endocarditis		INTERVAL BETWEEN ONSET AND DEATH 3 months	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Colioform organism	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Rheumatic Heart Disease, decompensated with mitral stenosis & insufficiency & DUE TO (c) Aortic stenosis & insufficiency, tricuspid insuff. Rt. & lf. ventricle hypertrophy; rt. & lf. auricular enlargement.	
II. OTHER SIGNIFICANT CONDITIONS Contributing to the death but not related to the disease or condition causing death.		3 "	
19a. DATE OF OPERATION June 1954		19b. MAJOR FINDINGS OF OPERATION at K. U. Medical Center "Mitral Valvulotomy"	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		410X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-10</u> , 1954, to <u>4-5</u> , 1956, that I last saw the deceased alive on <u>4-5</u> , 1956, and that death occurred at <u>12:15 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>Colles Rowandy MD</i>		23b. ADDRESS <i>St. Joseph, Mo.</i>	
23c. DATE SIGNED 4-6-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/8/56	
24c. NAME OF CEMETERY OR CREMATORY Miller Cemetary		24d. LOCATION (City, town, or county) (State) Albany Missouri	
DATE REC'D BY LOCAL REG. Apr 13, 1956		REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i>	
FURNERAL DIRECTOR'S SIGNATURE <i>John S. Kuff</i>		ADDRESS St. Joseph, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rupp's

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 *Allvin E. Bagan* .....

Licensed Embalmer No. *479*.....

P. O. Address *St. Joseph*.....

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.