LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

9200

1. PLACE OF DEATH
County Dallas — Registration District No. 242 — File No. 3
Township Grant — Primary Registration District No. 5335 — Registered No. 3
City ~~Buffalo Mo~~ — St. — Ward)

2. FULL NAME Guy D Killion
(a) Residence. No. — St., — Ward. — (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lizzie Killion

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 6/26/1900

7. AGE: Years 20 — Months 9 — Days 22 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): missouri

PARENTS
10. NAME OF FATHER: Fred Killion
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kansas
12. MAIDEN NAME OF MOTHER: Cox
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): missouri

14. INFORMANT: Fred Killion
(Address): Buffalo, Mo.

15. FILED 4/25, 1921 — W E Gammon, REGISTRAR

2 **MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4/18 1921

17. I HEREBY CERTIFY, That I attended deceased from 4/17/21, 19__, to 4/18, 1921, that I last saw him alive on 4/18, 1921, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremic Poisoning
59
132B
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY): Diabetis Melitis
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of Death
9 DID AN OPERATION PRECEDE DEATH? + DATE OF 6-4-18
WAS THERE AN AUTOPSY? Now
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W E Gammon, M.D.
, 19 (Address) Louisburg 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Lindley Cemmetery — DATE OF BURIAL: 4/19 1921

20. UNDERTAKER: C E Routh — ADDRESS: Buffalo Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. .....Ward)

2. FULL NAME .....

(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. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....,19.....
that I last saw h..... alive on.....,19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....,M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS