

THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

1390

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence Mo (No. 412)

Registration District No. 398

Primary Registration District No. 3079

File No. _____
Registered No. 25
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 412 U. S. Highway St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. 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)

a a Killipian

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Robert A. Killipian

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 23 - 1875

7. AGE

YEARS

MONTHS

DAYS

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

73

8

—

8. OCCUPATION OF DECEASED

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

None

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

1

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Blue Springs Mo
(STATE OR COUNTRY)

10. NAME OF FATHER

Gen S. W. Winters

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Danville Ky

12. MAIDEN NAME OF MOTHER

C. Holladay

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

14.

INFORMANT

(Address)

Mr. H. W. Winters
Independence Mo

15.

FILED

19

REGISTRAR

A. W. Winters

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/22 1929

17. I HEREBY CERTIFY That I attended deceased from Dec 1 1928 to Jan 22 1929

that I last saw him alive on Jan 22 1929, and that
death occurred, on the date stated above, at 5:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

108

930

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) lobar pneumonia

(duration) yrs. mos. ds.

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? Clinical

(Signed) J. H. Greene M. D.

1/22 1929 (Address) Independence 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

DATE OF BURIAL

Blue Springs

Jan 23 1929

20. UNDERTAKER

Ort & Mitchell

ADDRESS

Indep.

1. The first of these is the

second of these is the

third

fourth

fifth

sixth

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson Registration District No. 298 File No. _____
Township _____ Primary Registration District No. _____ Registered No. 25
City Indef. (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 F 4. COLOR OR RACE W. 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) _____

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) _____

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 Feb 11 1929 F. L. Cook
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 23 1929 19

17.

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

THIS IS A PERMANENT F

carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-1390