

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. St. Joseph Hospital)

File No. 9665
Registered No. 372
St. _____ Ward)

2. FULL NAME Helen Chalmers Kilgore

(a) Residence. No. 2903 St. Joseph Ave. St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 33 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) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF **Alonzo W Kilgore**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 4, 1882**

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
	46	8	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **House-wife**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Stubenville**
(STATE OR COUNTRY) **Ohio**

10. NAME OF FATHER **James F Stephens**

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

12. MAIDEN NAME OF MOTHER **Mary E Tubble**

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

14. INFORMANT **Alonzo W Kilgore**
Address) **2903 St. Joseph Ave.**

15. FILED 20 1929 **John G. [Signature]** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 18** 1929

17. I HEREBY CERTIFY. That I attended deceased from Jan. 29 1929 to March 17 1929.
that I last saw h. OR alive on March 17 1929, and that death occurred, on the date stated above, at 2:25 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Postoperative Acute Gastric Dilatation

(duration) _____ yrs. _____ mos. 1 ds.
CONTRIBUTORY (SECONDARY) *Uterine Fibroid. Secondary Anemia*
(*Non-Malignant*) (duration) 7 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

1899
IF NOT A PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF March 13

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical + operative
(Signed) Bluery M. Froumer, M. D.

Mar. 18, 1929 (Address) 215 P. S. Bldg. St. Joseph 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 **Memorial Park Cemetery** DATE OF BURIAL **Mar. 20 1929**

20. UNDERTAKER **H. O. Sidenfaden** ADDRESS **1802 Union St.**

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.

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