

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

Do not use this space.
42620
File No. _____
Registered No. **12401**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Peter M. Killenme

(a) Residence. No. **6116 E. 9th St.** Ward **5**
(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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mrs Peter Killenme</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct 20 - 1872</i>		
7. AGE	YEARS <i>57</i>	MONTHS <i>1</i>
	DAYS <i>29</i>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Painter</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>House Painter</i> (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Lafayette Ind</i>		
PARENTS	10. NAME OF FATHER <i>Mathew Killenme</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Ind</i>	
	12. MAIDEN NAME OF MOTHER <i>Margaret Reusser</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Ind</i>	
14. INFORMANT <i>Mrs P. Killenme</i> (Address) <i>6116 E 9th St</i>		
15. FILED _____ 19 _____ <i>W. C. Barker</i> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 19 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 4 1929* **to** *Dec 19 1929*
that I last saw him alive on *Dec 18 1929* **and that death occurred, on the date stated above, at** *5:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of Heart

CONTRIBUTORY (SECONDARY) *Broncho-Pneumonia* (duration) _____ yrs. _____ mos. _____ ds.
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18. WHERE WAS DISEASE CONTRACTED *10th St*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* **DATE OF** _____
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *O. C. Cairnes* M. D.
12/20 1929 (Address) *370 Main Bldg*

*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 <i>St Peter's Cem</i>	DATE OF BURIAL <i>Dec 23 1929</i>
20. UNDERTAKER <i>Chas. L. Dwyer</i>	ADDRESS <i>482 W. 11th St</i>

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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