500

DEC 23 1930

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

Do not use this space.

38318

1. PLACE OF DEATH
County: Vernon — Registration District No. 875 — File No.
Township: — Primary Registration District No. 6162 — Registered No. 259
City: (No. , St. Ward)

2. FULL NAME: Samuel Killian
(a) Residence. No. State Hosp # 3 St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 43 yrs. 4 mos. 24 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)
m	w	single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: none

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dk. 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	74	—	—	

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):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): unknown

14. INFORMANT: State Hosp Record
(Address): Nevada Mo

15. FILED 12-1-1930 E. R. King, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 14 1930

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to Nov 14, 1930, that I last saw him alive on Nov 14, 1930 and that death occurred, on the date stated above, at 10:10 P m.

93C THE CAUSE OF DEATH* WAS AS FOLLOWS:
77
Chronic myocarditis (duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH unknown
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) E H Coon, M. D.
11-14. 1930 (Address) Nevada 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: Nevada — DATE OF BURIAL: 11-15-30
20. UNDERTAKER: Myers — ADDRESS: Nevada

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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD