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

684 2434

FEB 20 1931

1. PLACE OF DEATH
County: Pike
Township: Cuivre
City: Bowling Green (No. ..... St. ..... Ward)
Registration District No.: 4108
Primary Registration District No.:
File No.:
Registered No.: 8

2. FULL NAME: George R. Chilton

(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 30 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~~ Blanch E. Chilton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 11 - 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	11	16	

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): at Handle Factory
(c) Name of employer: Guy Meek

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

PARENTS

10. NAME OF FATHER: A. J. Cilton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Nancy Kelso
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky.

14. INFORMANT: Alma Langford
(Address): Bowling Green Mo

15. FILED: Feb 3 1931, 19.....
W. S. Hammerman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1931

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:
Gun Shot Wound
1/2 Inflicted By his own
Friend with
Suicide intent
(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) J. S. Hendy Coroner, M. D.
, 19 (Address) Bowling Green Mo

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*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: Bowling Green Cemetery
DATE OF BURIAL: Jan. 29 1931

20. UNDERTAKER: N. B. Elmore
ADDRESS: Bowling Green

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.

...EN WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

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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

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....., 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

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