

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

Do not use this space.

AUG 15 1936

25602

1. PLACE OF DEATH

County Buchanan
Township Washington
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. State Hosp # 2)

File No. _____
Registered No. 963
St. _____ Ward _____

2. FULL NAME

Manerwa Jane Kilgore
(a) Residence, No. Kansas City, Mo. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 25 da. 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 Widow (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. Kilgore - Deceased

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 31 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
Est 60 11 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home
10. Date deceased last worked at this occupation (month and year) 1932 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas
Unknown

FATHER 13. NAME Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
Unknown

MOTHER 15. MAIDEN NAME Mary Anne

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
Unknown

17. INFORMANT (ADDRESS) Records State Hosp # 2
St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospital
St. Joseph, Mo. DATE July 21, 1936

19. UNDERTAKER (ADDRESS) H. O. Sidenfaden
1802 Union Str St. Joseph, Mo.

20. FILED 7-21 1936 A. J. Neillbush
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19, 1936

22. I HEREBY CERTIFY. That I attended deceased from Nov 19, 1935, to July 19, 1936.
I last saw h.c.e. alive on July 19, 1936. Death is said to have occurred on the date stated above, at 9:30 p.m.

The principal cause of death and related causes of importance were as follows:

Paresis
Date of onset 1932
plus

Other contributory causes of importance: 

Name of operation none Date of _____
Whattest confirmed diagnosis Laboratory Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) E. E. DeLong, M. D.
(Address) State Hosp # 2

1974

580

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

Do not use this space.

1. PLACE OF BIRTH

County Buchanan

Registration District No. 85-

File No.

Township St Joseph

Primary Registration District No. 1001

Registered No. 963

City St Joseph (No.) St. Ward)

2. FULL NAME Minerva Jane Kilgore

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) widow

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, or min
	<u>60</u>	<u>11</u>	<u>19</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED July 2, 1936 A. J. Wetzel Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19, 1936

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19.....

I last saw him alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

paralysis Date of onset

General Paralysis of the Insane
Syphilitic origin
E. P. DeLong M.D.

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) E. P. DeLong, M. D.

(Address) St Joseph

SUPPLEMENT

S-25602

RECEIVED
FEB 11 1964