

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

33205
 Do not use this space.

DEC 20 1939

1. PLACE OF DEATH *Pettis 7*
 (a) County *Pettis 7* Registration District No. *668*
 (b) Township *1* Primary Registration District No. *3032*
 (c) City *Sedalia* (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Nancy Costello Kilgore*
 (a) Residence, No. *514 Wilkerson* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* **4. COLOR OR RACE** *W* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** *widowed*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *William Logan Kilgore*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 4, 1866*
7. AGE YEARS *73* MONTHS *3* DAYS *2* If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. *At Home*
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) *Sedalia Mo*

FATHER
13. NAME *Do not know first name Costello*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*

MOTHER
15. MAIDEN NAME *Mary C. Connors*

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

17. INFORMANT (NAME) (ADDRESS) *Mrs. Charles Logan Sedalia, Mo.*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Calvary* DATE *10/9 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *McLaughlin Bros Sedalia*

20. FILED *10-9-* 1939 *Mrs. H. Small 906*
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 6 1939*

22. I HEREBY CERTIFY, That I attended deceased from *April 10 1939* to *Oct. 6 1939*
 I last saw him alive on *Oct. 3 1939*. Death is said to have occurred on the date stated above, at *3:30 am*.
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
arterio-sclerosis
 Other contributory causes of importance:
arterio-sclerosis

Date of onset of *brain hemorrhage*
no info known

Name of operation *none* Date of *time*
 What test confirmed diagnosis? *Chum* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *h* 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) _____, M. D.
 (Address) *Sedalia, Mo.*

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Ralph E. Baker

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Ralph E. Baker

Licensed Embalmer No. *2419*

P. O. Address *Sedalia*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.