

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Missouri Pacific Hospital
(d) Length of stay: In hospital or institution 3 weeks
In this community 3 weeks

3. (a) PRINT FULL NAME Samuel Horton Killian

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Hattie M. 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Apr. 6, 1874

8. AGE: Years 65 Months 10 Days 26 If less than one day. hr. _____ min. _____

9. Birthplace Oxford, New Jersey

10. Usual occupation Engineer (Retired)

11. Industry or business Terminal Ry. Co.

12. Name Thomas J. Killian

13. Birthplace Lancaster, Penn.

14. Maiden name Mary E. Call

15. Birthplace Oxford, N. J.

16. (a) Informant's own signature J. Meneatoris

(b) Address East St. Louis, Ill.

17. (a) E. St. Louis, Ill. (b) Date thereof Mar. 5, 1940

(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director [Signature]

(b) Address East St. Louis, Ill.

19. (a) MAR 4 1940 (b) [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
(c) City or town East St. Louis, R. 1
(d) Street No. Centerville Station
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 2
year 1940 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 2-6, 1940 to 3-2, 1940
that I last saw him alive on 3-2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Heart disease

Carcinoma of sigmoid

Due to _____

Other conditions [Signature]
(Include pregnancy within 6 months of death)

Major findings: Carcinoma of sigmoid
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature Geo. W. Blankenship (M. D. or other) [Signature]
Address 1755 S. Grand Date signed 3-3-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1 X1931

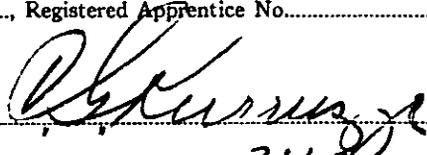
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....


Licensed Embalmer No. 3162

P. O. Address East St. Louis, I

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.