

STANDARD CERTIFICATE OF DEATH

State File No. 22706

Registration District No. 1053

Primary Registration District No. 6004

Registrar's No. 5

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Collins (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Abel Killingsworth
3. (b) If veteran, name war _____
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 16 1854
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>10</u>	<u>15</u>	_____ hr. _____ min.

9. Birthplace Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Minster

11. Industry or business _____

MOTHER FATHER
12. Name William Killingsworth
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Sally Stone
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Harry Elliott
(b) Address Collins, Mo.

17. (a) Burial (b) Date thereof June 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Joseph T. ...
(b) Address Collins, Mo.

19. (a) June 12-1940 (b) O. E. Burton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair
(c) City or town Collins (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 1 1939, 1939, to Jan 1 1940, 1940, that I last saw him alive on Monday 31, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Duration _____

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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? _____
(City or town) (County) (State)
(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 _____

23. Signature D. E. Braun (M.D. or other) D.O.
Address Collins Mo Date signed Jan 3 1940

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

RECEIVED
District Health Officer No. 7,
District File Number 7-40-1021
Date Filed 7-8-48

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 Paul Justine

Licensed Embalmer No. 3990

P. O. Address Collins, MD

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 22706

Registration District No. 768

Primary Registration District No. 6003

Registrar's No.

1. PLACE OF DEATH

(a) County St. Clair
(b) City or town Callaway - Rural
(c) Name of hospital or institution Callaway Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME

Abel Killingsworth

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married divorced wed

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased 7 - 16 - 1885 (Month) (Day) (Year)

8. AGE: Years 85 Months 10 Days 15 If less than one day hr min

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) June 12 (Date received local registrar) (b) O. E. Burton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 1 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above. Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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? (City or town) (County) (State)

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

While at work (Specify type of place) (c) Means of injury

23. Signature Dr. Ed Brown, D.O.

Address Callaway Date signed

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-22700