

Registration District No. 198

Primary Registration District No. 5277A

Registrar's No. 137

1. PLACE OF DEATH

(a) County Ray

(b) City or town Marion

(c) Name of hospital or institution: Marion Mo

(d) Length of stay: In hospital or institution no

In this community 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray

(c) City or town Lawson Rural

(d) Street No. Rural South East

(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME JOHN WILSON KILGORE

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31st

year 1940 hour 6 minute 45 P. M.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single

6. (c) Age of husband or wife, if alive years

7. Birth date of deceased Mar 16 1861

21. I hereby certify that I attended the deceased from August 1940, 19 to , 1940

that I last saw him alive on August 31, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

8. AGE: Years 79 Months 7⁵ Days 5 15 hr. min.

Due to Arterial Sclerosis

Due to

9. Birthplace Rayville Ray Co Mo

10. Usual occupation Farming

Other conditions

Major findings: Of operations

Of autopsy none made

11. Industry or business

12. Name Andrew J. Kilgore

18. Birthplace Marion Mo

14. Maiden name Polly Searey

15. Birthplace Marion Mo

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?

16. (a) Informant John Kilgore

(b) Address Marion Mo

23. Signature Thos J. Trace (M. D. or other) 15/40

Address Collins Springs Mo Date signed 9/24/40

17. (a) Burial (b) Date thereof Sept 3-40

(c) Place: burial or cremation Union Ray Co

18. (a) Signature of funeral director

(b) Address

19. (a) Sept 3-40 (b) Mrs R. M. Cracker

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

24

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-9-40

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 Virgil Hope
Licensed Embalmer No. 3950
P. O. Address Excelsior Springs

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

State File No. **31754**
Registrar's No. **137**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **198**

Primary Registration District No. **2277A**

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

1. PLACE OF DEATH
(a) County **Clayton**
(b) City or town **7th Street R. T. P.**
(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 **John Wilson Kilgore**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased **mar-16-1861**
(Month) (Day) (Year)

8. AGE: **79** years **5** Months **15** Days 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **11-18-40** (b) **Mr. Rex M. Cuckey**
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month **Aug** day **21**
year _____ 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) _____ (e) Means of injury _____

23. Signature **John J. Ingers** (M. D. or other)
Address **St. Charles, Mo.** Date signed **11-18-40**

SUPPLEMENTAL CERTIFICATION

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

