

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 33800
Registrar's No. 8497Registration District No. 791 Primary Registration District No. 1003

PLACE OF DEATH:

(a) County St Louis Mo
 (b) City or town St Louis Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days (Specify whether
 In this community _____
 years, months or days)

8. (a) PRINT FULL NAME Mary Madeline Kileummings8. (b) If veteran, name war No. 8. (c) Social Security No. None4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive 44 years7. Birth date of deceased June 15 1895
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
45 3 28 hr. min.9. Birthplace Riverton Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Housewife 4

11. Industry or business _____

12. Name William G. Smith 113. Birthplace Manchester England
(City, town, or county) (State or foreign country)14. Maiden name Bridget Fleming15. Birthplace Vermont
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Dr. R. E. Smith(b) Address Springfield, Ill.17. (a) Removal (b) Date thereof 10/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Springfield, Ill.18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Ave.19. (a) OCT 14 1940 (b) J. P. Predeck
(Received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Sangamon
 (c) City or town Springfield NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1720 Lowell Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13
year 1940 hour 8:53 minute P. M.21. I hereby certify that I attended the deceased from OCT. 11, 1940
_____, 19____, to October 13, 1940that I last saw her alive on October 13, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Pulmonary edema & Broncho-pneumonia Duration 20 hrsDue to Subarachnoid hemorrhage following abdominal incision 36 hrsDue to Under spinal anesthesia operation for ventralOther conditions herpes

(Include pregnancy within 6 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 Samuel H. Harrison (M. D. or other) MDAddress BARNES HOSPITAL Date signed 10/13/40

Kilburnings

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed *Albert G. Hopper*

Licensed Embalmer No. *2971*

P. O. Address.....

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.