

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

34273

Registration District No. 791Primary Registration District No. 1003Registrar's No. 8970

PLACE OF DEATH:

- (a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hours
(Specify whether In this community About 50 years
years, months or days)

3. (a) PRINT FULL NAME George F. Kilian
(b) If veteran, name war no
(c) Social Security No. 491-12-962

4. Sex male 5. Color or race white
6. (b) Name of husband or wife Louise Kilian
7. Birth date of deceased Dec. 23, 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation Harness Maker

11. Industry or business _____

12. Name Jacob Kilian
13. Birthplace unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Louise Kilian
(b) Address 1928 Angelrodt St.

17. (a) burial (b) Date thereof Nov. 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Goodhart & Goodhart
(b) Address 2228 St. Louis Ave

19. (a) OCT 31 1940 (b) J. J. Bradeck
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 1928 Angelrodt St.
(If rural, give location)
(e) If foreign born, how long in U.S. 2 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th
year 1940 hour 7:00 minute A. 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 Chronic Interstitial Nephritis;
Arteriosclerosis;

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)
(a) Means of injury _____

23. Signature Alfred G. Perry (M. D. or other) _____
Address 1928 Angelrodt St. Date signed 10/31/40

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

Charles J. Hoppe
.....
Licensed Embalmer No. *2777*

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.