

**FILED MAR 4 3 1944**  
Registration District No. **224**

Primary Registration District No. **4204**

Registrar's No. **218**

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

**1. PLACE OF DEATH:**  
(a) County Grundy  
(b) City or town Laredo, mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Street not numbered  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life time years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Grundy  
(c) City or town Laredo  
(If outside city or town limits, write "RURAL")  
(d) Street No. not numbered  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** IRA JACKSON KILBURN

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 Thelma Kilburn 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Nov (Month) 2 (Day) 1863 (Year)

8. AGE: Years 80 Months 2 Days 6 If less than one day hr. \_\_\_\_\_ min \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name David Kilburn

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

14. Maiden name Elizabeth Jackson

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

16. (a) Informant Hittie Kilburn

(b) Address Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Stuckert Cemetery

18. (a) Signature of funeral director L. S. Roberts

(b) Address Laredo, mo

19. (a) 2-14-44 (Date received local registrar) (b) L. S. Roberts (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 8<sup>th</sup> year 1944 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from February 6<sup>th</sup> 1944 to February 8<sup>th</sup> 1944.  
that I last saw him alive on February 8<sup>th</sup> and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration 2 days?  
Due to Arteriosclerosis ?

Due to Uremic poisoning

Other conditions (Include pregnancy within 3 months of death)

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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) (6) Means of injury 2

23. Signature B. Lee Shelhorse (M.D. or other) DD  
Address Box 129 Laredo, Mo. Date signed 2-9-44

1530

**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.....

*John H. Robertson*....., Registered Apprentice No. *255*  
working under my personal supervision.

Signed *J. H. Robertson*.....

Licensed Embalmer No. *2465*.....

P. O. Address *Fairfax, Va.*.....

**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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED 254  
MAR 19

Registration District No. 432

Primary Registration District No. 4204

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Grundy  
 (a) County Grundy  
 (b) City or town Fansley  
 (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 W. Jackson Kilburn  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, W widowed, married, divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 2 1924  
 (Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.  
 9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 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) \_\_\_\_\_ (b) \_\_\_\_\_  
 (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day \_\_\_\_\_  
 year 1964 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Cardiac Failure Duration \_\_\_\_\_

Due to arteriosclerosis  
 Due to Wernicke's Encephalopathy  
from Chronic Alcoholism  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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 B. Lee Shelton (M. D. or other) PO  
 Address Lindsay, Mo. Date signed 3-18-64

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

SUPPLEMENTARY

