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FORM 8-43  
Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

*Robert*

State File No. **33008**

**FILED** OCT 16 1945 **STANDARD CERTIFICATE OF DEATH**

Registration District No. 9 Primary Registration District No. 5036 Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jefferson  
 (b) City or town Shelton  
 (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** LLOYD ORLO KILBURN  
**3. (b) If veteran,** name war no  
**3. (c) Social Security** No. 499-243612  
**4. Sex** MO **5. Color or race** W  
**6. (a) Single, widowed, married, divorced** Married  
**6. (b) Name of husband or wife** Paula Mae Kelburn **6. (c) Age of husband or wife if alive** 45 years  
**7. Birth date of deceased** 12 (Month) 2 (Day) 1891 (Year)

8. -AGE:				If less than one day
Years	Months	Days	hr.	
<u>53</u>	<u>10</u>	<u>0</u>		

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

**10. Usual occupation** Farmer

**11. Industry or business**

**12. Name** Chas. Kelburn  
**13. Birthplace** Alleston Iowa (City, town, or county) (State or foreign country)  
**14. Maiden name** Lucille Brown  
**15. Birthplace** Quay Co Mo. (City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. Lucille Kelburn  
**(b) Address** Washington Texas

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** 10/7-1945 (Month) (Day) (Year)  
**(c) Place: burial or cremation** Centralia Mo Cem.

**18. (a) Signature of funeral director** \_\_\_\_\_  
**(b) Address** \_\_\_\_\_

**19. (a)** 10/6-1945 **(b)** \_\_\_\_\_ (Date received from Registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (County) Jefferson  
 (c) City or town Centralia Rural (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Oct day 2 year 1945 hour 11 minutes 15 P. M.  
**21. I hereby certify that I attended the deceased from** Sept 2 1945, to Oct 2 1945  
 that I last saw him alive on Oct 2 1945; and that death occurred on the date and hour stated above.

**Immediate cause of death** Carcinoma of lower maxillary throat 13 yr.  
**Due to** Malnutrition due to cancer  
**Due to** \_\_\_\_\_

**Other conditions** (Include pregnancy within 3 months of death) \_\_\_\_\_

**Major findings:** Of operations 458  
**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? \_\_\_\_\_

**23. Signature** R. T. Whit (M. D. or other) \_\_\_\_\_  
**Address** Centralia, Mo **Date signed** 1945 Oct 3

**PHYSICIAN**  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

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**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 *M. J. McDaniel*

Licensed Embalmer No. 4313

P. O. Address Centralia Mo.

**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.**