

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED JAN 8 1945 STANDARD CERTIFICATE OF DEATH

State File No. **40600**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1376**

1. PLACE OF DEATH:

(a) County **Buckanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **General Osteopathic Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 hours**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

James Andrew McKillip

3. (b) If veteran, name war **none**

3. (c) Social Security No. **none**

4. Sex **M**

5. Color or race **W**

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

6. (b) Name of husband or wife **—**

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

7. Birth date of deceased **12-20-1945**
(Month) (Day) (Year)

8. AGE:

Years **0**

Months **0**

Days **0**

If less than one day / **15** hr. min.

9. Birthplace **St. Joseph**
(City, town, or county)

MO
(State or foreign country)

10. Usual occupation **none**

11. Industry or business

12. Name **Harold McKillip**

13. Birthplace **Pickering** **MO**
(City, town, or county) (State or foreign country)

14. Maiden name **Berniece Snapp**

15. Birthplace **Nodaway** **MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Harold McKillip**

(b) Address **Fillmore** **MO**

17. (a) **B.** (b) Date thereof **12-22-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Savannah**

18. (a) Signature of funeral director **E. C. Breit**

(b) Address **Savannah** **MO**

19. (a) **Dec. 26, 1945** (b) **A. J. Nestle**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Andrew** **2**
(c) City or town **Fillmore**
(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 **12** day **21**
year **1945** hour **2** minute **A.M.**

21. I hereby certify that I attended the deceased from **12-20**, 19**45**, to **12-21**, 19**45**
that I last saw him alive on **12-20**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death

Premature Birth
6 wks. Premature

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **15**

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) (e) Means of injury _____

23. Signature **Clifford L. Studley** D. or other **MD**
Address **Doonuch** **MO** Date signed **12-24-45**

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

MOTHER FATHER

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.....

E. C. Breit

Licensed Embalmer No. *2650*

P. O. Address *Savannah*

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.