

No. 2
-8-13
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19657
Registrar's No. 224

FILED JUN 7 9 1946
Registration District No. 7

Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hosp # 12
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 yrs 2 months 8 days
(Specify whether)

In this community Same
years, months or days

3. (a) PRINT FULL NAME Calvin H. Kile

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased DK DK
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>DK</u>	<u>DK</u>	hg. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name DK DK

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

14. Maiden name DK DK

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

16. (a) Informant Wm. J. Read

17. (a) J. M. Read (b) Date thereof June 26, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp Cemetery

18. (a) Signature of funeral director Wm. J. Read

(b) Address Fulton, Mo

19. (a) June 26-46 (b) Joice Morsinkhoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway

(c) City or town Callow City
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1946 hour 12 noon minute M.

21. I hereby certify that I attended the deceased from March
1 1946, to June 23, 1946
that I last saw him alive on June 22, 1946
and that death occurred on the day and hour stated above.

Immediate cause of death

Carcinoma of Stomach

Due to Carcinoma of Prostate

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

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

Signature Wm. J. Read (M. D. or other)

Address Fulton, Mo Date signed 6/27/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-8-46

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 224

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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

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 _____

3. (a) PRINT FULL NAME Calvin H. Kile

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased OK
(Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days _____ (Less than one day)
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 19 Year 1946
yes _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

2 separate & distinct primary carcinomas

Due to Carcinoma of the stomach

Due to Carcinoma of the prostate

Other conditions _____
(Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: _____

Of operations _____

Of autopsy 46N

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

18533

19657