S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

26048

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27207

FILED SEP 3 1946

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3623

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital No. 1 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 911 W. 14 St. 8
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Kilgore

3. (b) If veteran, name war no

3. (c) Social Security No. 500-14-9347

4. Sex male 0

5. Color or race White

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased March 5, 1899 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
47	5	14	hr. min.

9. Birthplace Marian (City, town, or county) Kansas (State or foreign country) 1

10. Usual occupation Brick layer

11. Industry or business

FATHER
12. Name James Kilgore
13. Birthplace unknown (City, town, or county) Indiana (State or foreign country) 1

MOTHER
14. Maiden name Stella Stewart
15. Birthplace unknown (City, town, or county) Iowa (State or foreign country) 1

16. (a) Informant Miss Cora F. Kilgore

(b) Address 911 West 14th Street

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cemetery, Johnson Co. Kans.

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 Olathe Blvd. K.C.K.

19. (a) 8-21-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19 year 1946 hour 7 minute 50 A.M.

21. I hereby certify that I attended the deceased from August 6, 1946, to August 19, 1946; that I last saw him alive on August 19, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bacterial endocarditis acute	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 91a.	

Major findings:
Of operations
Of autopsy See above

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Wm. W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 8-19-46

(Licensed Embalmer's Statement on Reverse Side)

Dr. Ellison

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. D Ross Blanford

Licensed Embalmer No. 4610

P. O. Address. 41 State Line

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.