. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 26 1948

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 44364

Registration District No. 756

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:
(a) County: Jasper
(b) City or town: Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Freeman
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: since birth (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasper
(c) City or town: Joplin
(If outside city or town limits, write "RURAL")
(d) Street No.: 1915 Pennsylvania
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Tweed Raymond Killian
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: F. 1
5. Color or race: W.
6. (a) Single, widowed, married, divorced: child
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: December 8, 1947 (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day: 33 hr. min.

9. Birthplace: Joplin (City, town, or county) Missouri (State or foreign country)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Wesley R. Killian
13. Birthplace: St. Louis, Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Joan Tweed
15. Birthplace: Beloit, Kansas (City, town, or county) (State or foreign country)

16. (a) Informant: Mr. Wesley R. Killian
(b) Address: 1915 Pennsylvania, Joplin Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 12-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Ozark Memorial
18. (a) Signature of funeral director: Parker-Hunsaker
(b) Address: Joplin, Missouri
19. (a) 12-13-47 (Date received local registrar) (b) Dolores Lampkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 10 year: 1947 hour: 2 minute: 30 A.M.
21. I hereby certify that I attended the deceased from 12-8, 1947, to 12-10, 1947; that I last saw him alive on 12-10, 1947; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Cerebral hemorrhage

Due to:

Due to:

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

Major findings:
Of operations:
Of autopsy:

PHYSICIAN

Underline the cause of 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:
23. Signature: [illegible] (M.D. or Coroner)
Address: Joplin Date signed: 12/11/47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

47-12-1068

## 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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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.

S. No. 2B>
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Fet

Registration District No. 156 Primary Registration District No. 2001 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Jasper

(b) City or town Joplin
(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** Tweed R. Kellian

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 8 (Day) 1947 (Year)

8. AGE: Years Months Days If less than one day 33 hr. min.

9. Birthplace (City, town, or county) N/O (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 12-13-47 (Date received local registrar) (b) Dolores Lampkins D.R. (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day
year 1947 hour minute M.

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

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-44364