

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38282

82
2

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

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Louisiana	
d. FULL NAME OF HOSPITAL OR INSTITUTION 619 S. Main St.		d. STREET ADDRESS (If rural, give location) 619 S. Main	

3. NAME OF DECEASED (Type or Print)	a. (First) Samuel	b. (Middle) C.	c. (Last) Kilby	4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1949
-------------------------------------	--------------------------	-----------------------	------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 4, 1866	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 8 Days 6	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Pike County, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	---

13a. FATHER'S NAME J. W. Kilby	13b. MOTHER'S MAIDEN NAME Ellen Reed Kilby	14. NAME OF HUSBAND OR WIFE Cota Kilby (Deceased)
---------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Mrs. O.E. Sallings, Louisiana, Mo.	ADDRESS Louisiana, Mo.
---	--------------------------------------	---	-------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hypertensive Cordis		1 wk 442H
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. vascular disease			1 yr

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
---	--	---------------------------------

22. I hereby certify that I attended the deceased from _____, 19 **48**, to **11-10**, 19 **49**, that I last saw the deceased alive on **11-9**, 19 **49**, and that death occurred at **7:40 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Chas H. Lucille (M.D.)	23b. ADDRESS Louisiana, Mo.	23c. DATE SIGNED 11-10-49
--	------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/13/49	24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	24d. LOCATION (City, town, or county) (State) Louisiana, Mo.
---	---------------------------	--	---

DATE REC'D BY LOCAL REG. Nov 12, 49	REGISTRAR'S SIGNATURE Bernice Collier	25. FUNERAL DIRECTOR'S SIGNATURE George O. Wagner	ADDRESS Louisiana, Mo.
--	--	--	-------------------------------

RECEIVED NOV 5 1949
District Health Officer No. 33
District File Number 11-49-122
Date Filed NOV 15 1949

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

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed

George O. Wagner
Licensed Embalmer No. *3773*

P. O. Address

Louisiana, 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.