

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6053**  
**1071**

FILED MAR 13 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>  |  |
| c. LENGTH OF STAY (in this place) <u>29 YRS.</u>  |  | d. STREET ADDRESS (If rural, give location) <u>3921 TRACY</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSP.</u>                           |  |  |  |

3648

|   |  |
|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>LOCKIE</u> b. (Middle) <u>OLIVE</u> c. (Last) <u>KILLION</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>FEB. 18 1953</u> |
|---|--|

|                        |                               |  |                                      |   |   |   |
|------------------------|-------------------------------|--|--------------------------------------|---|---|---|
| 5. SEX <u>1</u> FEMALE | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>1 MARCH 1892</u> | 9. AGE (In years last birthday) <u>60</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 1 YEAR Hours _____ Mins. _____ |
|------------------------|-------------------------------|--|--------------------------------------|---|---|---|

|  |  |   |  |
|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br>X X X | 11. BIRTHPLACE (City and State or Foreign Country) <u>HUE, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>S. G. PORTER</u> | 13b. MOTHER'S MAIDEN NAME <u>AMY J. OLIVE</u> | 14. NAME OF HUSBAND OR WIFE <u>OTTO L. KILLION</u> |
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|   |   |   |                           |
|---|---|---|---------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>496-26-49590</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>L. KILLION</u> | ADDRESS <u>3921 TRACY</u> |
|---|---|---|---------------------------|

|   |                                    |  |                                  |
|---|------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)   | MEDICAL CERTIFICATION              |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u>  | DUE TO (b) <u>Carcinoma breast</u> |  | <u>6 mo</u>                      |
| ANTECEDENT CAUSES<br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | DUE TO (c) <u>None</u>             |  | <u>3 yrs</u>                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                               |                                    |  | <u>170h</u>                      |

|                                    |                                  |  |
|------------------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION <u>None</u> | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" 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) |
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|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 Feb. 3, 1953, to 2-18, 1953, that I last saw the deceased alive on 2-18, 1953, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|                                    |                               |                                   |                                 |
|------------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 23a. SIGNATURE <u>J. A. Tesson</u> | (Degree or title) <u>M.D.</u> | 23b. ADDRESS <u>907 Route 100</u> | 23c. DATE SIGNED <u>3/20/53</u> |
|------------------------------------|-------------------------------|-----------------------------------|---------------------------------|

|   |                             |   |  |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>20 FEB. 53</u> | 24c. NAME OF CEMETERY OR CREMATOR <u>FLORAL HILLS</u> | 24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u> |
|---|-----------------------------|---|--|

|  |   |  |         |
|--|---|--|---------|
| DATE RECD BY LOCAL REG. <u>2-20-53</u> | REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>FLORAL HILLS MEMORIAL CHAPELS K.C.</u> | ADDRESS |
|--|---|--|---------|

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

*Mr. J. E. ...*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Phyl C. McLeod*

Licensed Embalmer No. *4853*

P. O. Address *K. C. 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.