

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20314**

FILED JUN 10 1953
XC 238 01 81
REG# 111031
BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1526

1. PLACE OF DEATH a. COUNTY <u>ST. CLAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside Corporate Limits, write RURAL and give township) OR TOWN <u>JEFFERSON BARRACKS, MO.</u>		c. CITY OR TOWN <u>MASCOUTAH</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3 DAYS</u>		STREET ADDRESS (If rural, give location) <u>604 W. State</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VETERANS ADMINISTRATION HOSPITAL</u>			
3. NAME OF DECEASED (Type of Print) a. (First) <u>Earnest</u> b. (Middle) <u>H.</u> c. (Last) <u>KILIAN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6-1-53</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2-15-77</u>
9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>MASCOUTAH, ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>OTTO L. KILIAN</u>		13b. MOTHER'S MAIDEN NAME <u>MAGDALINE MILLER</u>	
14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES SPAW</u>		16. SOCIAL SECURITY NO. <u>325 14 3150</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>VA HOSPITAL RECORDS, JEFF BRKS, MO.</u>		ADDRESS _____	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease with Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH: <u>unknown</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <u>YES</u> 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 <u>5-29</u> , 19 <u>53</u> , to <u>6-1</u> , 19 <u>53</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. A. ALLEN</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>VET ADM HOSP., JEFF BRKS, MO.</u>	23c. DATE SIGNED <u>6-1-53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>6-2-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City</u>	24d. LOCATION (City, town, or county) (State) <u>Mascoutah, Ill.</u>
DATE REC'D BY LOCAL REG. <u>6-2-53</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Domb M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed: *J. W. Murphy*
.....
Licensed Embalmer No. *2653*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.