

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26564

State File No.

6353

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION D.O.A. Alexian Bros Hospital				e. STREET ADDRESS (If rural, give location) 5 5838 Plymouth Avenue.							
3. NAME OF DECEASED (Type or Print) a. (First) EDGAR			b. (Middle) ALBERT			c. (Last) KILLIAN			4. DATE OF DEATH (Month) (Day) (Year) June 25, 1953		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan 5, 1897		9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Supply Dept.				10b. KIND OF BUSINESS OR INDUSTRY Nooter Boiler Co.		11. BIRTHPLACE (City and State or Foreign Country) Fredricktown, Mo.				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Killian			13b. MOTHER'S MAIDEN NAME Barbara Pope			14. NAME OF HUSBAND OR WIFE Ora Killian					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War I			16. SOCIAL SECURITY NO. 91-07-1731		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss. Norma Killian, 5838 Plymouth Ave						
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES As for (b) and (c), if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		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) _____				21f. HOW DID INJURY OCCUR? 4201			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:00 A.M. m., from the causes and on the date stated above.							
23a. SIGNATURE Patrick Taylor Corcoran (Degree or title) _____				23b. ADDRESS 1300 Carl				23c. DATE SIGNED 6-25-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE June 26, 1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) Fredricktown, Missouri.					
DATE REC'D BY LOCAL REG. JUN 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home, 1167 Hamilton Ave					

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

APR 15 1954

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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 *Robert M. Murray*

Licensed Embalmer No. *374*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.