

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19830**

FILED JUL 16 1956

BIRTH NO. _____ REG. DIST. NO. **33** PRIMARY REG. DIST. NO. **3010** Registrar's No. **340**

1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) CAPE GIRARDEAU	c. LENGTH OF STAY (in this place) 7 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) CHAFFEE	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		d. STREET ADDRESS (If rural, give location) 204 ELLIOTT AVE.	

3. NAME OF DECEASED (Type or Print)	a. (First) Louis	b. (Middle) (NMN)	c. (Last) KILHAFNER	4. DATE OF DEATH (Month) (Day) (Year) July 5, 1956
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 25, 1872	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Month 02 Days 10	IF UNDER 4 RES. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (RET.)	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) NEW HAMBURG, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ANDREW KILHAFNER	13b. MOTHER'S MAIDEN NAME MELINA WITT	14. NAME OF HUSBAND OR WIFE CAROLINE KILHAFNER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME A.C. KILHAFNER	ADDRESS CAPE GIRARDEAU, Mo.
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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, asphyxia, 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) arteriosclerotic heart disease with congestive failure		
	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. senility			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6/29, 1956** to **7/5, 1956**, that I last saw the deceased alive on **6/14/56**, and that death occurred at **6:45** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) MD	23b. ADDRESS Cape Girardeau, Mo	23c. DATE SIGNED 7/11/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE July 7, 1956	24c. NAME OF CEMETERY OR CREMATORY GUARDIAN ANGEL CEM.	24d. LOCATION (City, town, or county) (State) ORAN, MISSOURI
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DATE REC'D BY LOCAL REG. 7-14-56	REGISTRAR'S SIGNATURE Elizabeth Sumner	25. FUNERAL DIRECTOR'S SIGNATURE Displinghoff	ADDRESS FUNERAL HOME - CHAFFEE, Mo.
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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
Student Embalmer

Signed

Jack J. Burnett

Licensed Embalmer No.

4473

P. O. Address

Chaffee, M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to complete the above constitutes grounds for revocation of license.)

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