

XC-2931 752

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3152
STATE FILE NUMBER
1016

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
-57
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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, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) 21870 4212 CLAYTON	
3. NAME OF DECEASED (Type or print) First Middle Last BIRL L. KILGORE		4. DATE OF DEATH Month Day Year JANUARY 26, 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/77
9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLAC. (City and state or country) ELECTRIC, ALABAMA	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME WILLIAM KILGORE		14. NAME OF HUSBAND OR WIFE ELIZABETH KILGORE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES SPAW		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			334x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sacral decubitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. ^{VA} attended the deceased from 12/18/57 to 1/26/58 and last saw ^{him} alive on 1/26/58 Death occurred at 5:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Leroy Fink</i> Leroy Fink (Degree or title) M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 1/26/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-29-1958	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR Cullinane Bros. 3320 N. Kingshighway		25. DATE RECD. BY LOCAL REG. JAN 28 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> mjs

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John D Denne*
Licensed Embalmer No. *4194*
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.