

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047059

STATE FILE NUMBER

FILED JAN 7 1959

Registration District No. 379 Primary Registration District No. 6282 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clark</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Norwood</u> 1140
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 1/2 Mi N/w Norwood</u>		Length of stay in 1b -----	d. STREET ADDRESS (If outside, give location) <u>2 1/2 Mi N/W Norwood</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Franklin Killian</u>			4. DATE OF DEATH Month Day Year <u>12-28-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1877</u>	
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>23</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Norwood, Missouri (Wright)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Moes Killian</u>		
13b. MOTHER'S MAIDEN NAME <u>Mray ussery</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Killian</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Bertha E. Killian</u>	Address <u>Norwood, Missouri</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Wright</u>	COUNTY <u>Wright</u>	STATE <u>Missouri</u>
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21. I attended the deceased from 12-2-1958 to 12-28-58 and last saw ^{her} him alive on 12-27-58
Death occurred at 2:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Wm Killian M.D.</u> (Degree or title)	22b. ADDRESS <u>Mtn. Grove Mo.</u>	22c. DATE SIGNED <u>12-30-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-30-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lone Star Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Wright Mtn Grove, Missouri</u>
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24. FUNERAL DIRECTOR <u>Ewell C. Craig</u>	ADDRESS <u>Mtn Grove, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>1-7-58</u>	26. REGISTRAR'S SIGNATURE <u>Thomas Chardon</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

JAN 23 1959

County of ...
Date Filed 1-6-1959

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 *Ewell C. Craig*

Licensed Embalmer No. *4766*

P. O. Address *Mt. View, Pa.*

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.