THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005804

STATE FILE NUMBER 1027

FILED MAR 11 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL — Length of stay in Hospital 12 HRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY DADE
c. CITY OR TOWN GREENFIELD 0290 0 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS *** (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First CORA Middle MAUDE Last PILKINGTON

4. DATE OF DEATH Month 2 Day 23 Year 1959

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH JUNE 12, 1889

9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months – Days – IF UNDER 24 HRS Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE

10b. KIND OF BUSINESS OR INDUSTRY NURSING

11. BIRTHPLACE (City and state or country) DADE COUNTY, MO.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JAMES T. AMOS

13b. MOTHER'S MAIDEN NAME MARGARET L. HOMES

14. NAME OF HUSBAND OR WIFE IRA PILKINGTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO (If yes, give war or dates of service) *****

16. SOCIAL SECURITY NO. 545-36-8640

17. INFORMANT MRS. L. DOLAN HOLMAN Address 404 S. LAWNDALE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertensive heart disease — 3 yrs
DUE TO (c) Arteriosclerosis.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4291

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE 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. I attended the deceased from 8-24-56, to 2-23-59 and last saw her alive on 2-23-59
Death occurred at 3:35 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. M. Haight (Degree or title) MD

22b. ADDRESS 3401 E 12th KC Mo

22c. DATE SIGNED 2-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE 2-24-1959

23c. NAME OF CEMETERY OR CREMATORY DAUGHTREY CEMETERY

23d. LOCATION (City, town, or county) (State) GREENFIELD, MISSOURI

24. FUNERAL DIRECTOR C. H. BLACKMAN & SON INC. **ADDRESS** K.C. MO.

25. DATE RECD. BY LOCAL REG. 2-24-59

26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. M. Haight

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 Wayne Smith, Student Embalmer No. 567 working under my personal supervision.

Student Wayne Smith
Signature of Student Embalmer

Signed W. C. Rinne

Licensed Embalmer No. 4829

P. O. Address K.C., Mo.

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.