

FILED VS JUL 3 0 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-026839

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar **3 6100**

S. 300  
v. 1-57

592

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5770 a McPherson</b>		Length of stay in lb <b>3 Years</b>	d. STREET ADDRESS (If outside, give location) <b>5770 a McPherson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Alice</b> Last <b>Killian</b>			4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1920</b>	9. AGE (In years birthday) <b>39</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barnes Hosp.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Harry Beckham</b>		13b. MOTHER'S MAIDEN NAME <b>Marie Bartlicia</b>		14. NAME OF HUSBAND OR WIFE <b>Robert L. Killian</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or type of service) <b>Yes W.W. #2</b>		16. SOCIAL SECURITY NO. <b>487-26-1489</b>		17. INFORMANT Address <b>Mrs. Theresa Dickerson, 3349 a So. Jefferson</b>	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intoxication by Naridone (R) following overdose of drug (exact time and date) (Addict)</b>					INTERVAL BETWEEN ONSET AND DEATH
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) <b>878.0 14</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <b>052</b>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
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 <b>SULLIVAN</b> COUNTY _____ STATE _____	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated					
22a. SIGNATURE <b>John M. Queen</b> (Degree or title) _____			22b. ADDRESS <b>1300 Paul</b>		22c. DATE SIGNED <b>6/29/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>June 30, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery,</b>	
				23d. LOCATION (City, town, or county) (State) <b>Sullivan, Missouri.</b>	
24. FUNERAL DIRECTOR <b>Wacker-Helderle, 3634 Gravois.</b> <b>St. Louis, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>JUN 29 '59</b>		26. REGISTRAR'S SIGNATURE <b>Neal Smith, M.D.</b>

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 Rehoboth J. Krupin  
Licensed Embalmer No. 3497  
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.