

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042080

FILED VS NOV 20 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210398**

ENDED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Park Lane Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS 4204 W. Kossouth (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle _____ Last Killion			4. DATE OF DEATH Month Nov. Day 11 Year 1959				
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 2 17 1917	9. AGE (last birthday) 42	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) Portageville Mo.			
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James Killion		13b. MOTHER'S MAIDEN NAME Cinda Buchanan			
14. NAME OF HUSBAND OR WIFE Esma Killion		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W. 2		16. SOCIAL SECURITY NO. _____			
17. INFORMANT Esma Killion		17. INFORMANT Address 4204 W. Kossouth					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Gastric Ulcer Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Peritonitis DUE TO (c) 540.0					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ 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 _____ COUNTY _____ STATE _____			
21. I attended the deceased from 11-4-59 to 11-11-59 and last saw ^{her} _{him} alive on 11-11-59 Death occurred at 6:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Frank J. Smith (Degree or title) M.D.				22b. ADDRESS 1930 Lindell Blvd.			
22c. DATE SIGNED 11-12-59							
23a. BURIAL CREATION, REMOVAL (Specify) Removal		23b. DATE Nov. 14, 1959		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			
23d. LOCATION (City, town, or county) St. Louis Co. Mo.		(State) _____					
24. FUNERAL DIRECTOR Leidner Undertaking 2223 St. Louis Ave. ADDRESS _____			25. DATE RECD. BY LOCAL REG. NOV 12 1959		26. REGISTRAR'S SIGNATURE <i>Frank J. Smith, M.D.</i>		

DOCUMENT

BY AFFIDAVIT OF

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 *James D. Wiley*
Licensed Embalmer No. 36
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.