MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED FEB 1 1960

-60-007213

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 24

1. PLACE OF DEATH
a. COUNTY: MACON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MACON — Length of stay in 1b: 3 WKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: SAMARITAN HOSP — Inside Limits: Yes ☒ No ☐

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

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: W Last: KILLEN
4. DATE OF DEATH: Month: JAN Day: 30 Year: 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JAN 24 1886
9. AGE (last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): KNOX COUNTY MO
12. CITIZEN OF WHAT COUNTRY: US
13a. FATHER'S NAME: HUGH M. KILLEN
13b. MOTHER'S MAIDEN NAME: RACHAEL WHITE
14. NAME OF HUSBAND OR WIFE: ELIZABETH KILLEN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 444-40-1100
17. INFORMANT: MRS CHARLES KILLEN Address:

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): Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Diabetes Mellitus — 20 yrs
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. ☐ Yes ☐ No ☐ Unknown

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 11/3/60, to Jan 30, 1960 and last saw her/him alive on Jan 30, 1960
Death occurred at 12:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James E. Campbell (Degree or title): MD
22b. ADDRESS: Macon Mo.
22c. DATE SIGNED: 2/2/60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 2-1-60
23c. NAME OF CEMETERY OR CREMATORY: CHERRY BOX CEMETERY
23d. LOCATION (City, town, or county) (State): SHELBY COUNTY MO

24. FUNERAL DIRECTOR: GREENING ADDRESS: CLARENCE MO
25. DATE RECD. BY LOCAL REG.: 2/6/60
26. REGISTRAR'S SIGNATURE: Ruth Mueller

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Charles V. Green

Signature of Student Embalmer

Licensed Embalmer No. 462

P. O. Address Clarence

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor 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.