

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004093

FILED VS FEB 14 1961

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 207

DATE AMENDED
5/2/61
5/2/61
5/2/61

INSTEAD OF
Deferred for autopsy

DOCUMENT

BY AFFIDAVIT OF
Attending physician

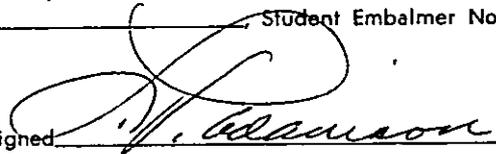
ITEM NO. SHOULD READ
18a Cerebral hemorrhage
18b Sepsis
18c Toxemia

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NORMANDY</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>FREDERICKTOWN</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NORMANDY Osteopathic</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>KILLIAN</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>
11a. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Wm. Edward Killian</u>		13b. MOTHER'S MAIDEN NAME <u>Connie Wilkinson</u>	
14. NAME OF HUSBAND OR WIFE		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>William E. Killian</u>	
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>Cerebral Hemorrhage</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Sepsis</u>			
DUE TO (c) <u>Toxemia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Volvulus of Mid-gut (Neonatal)</u>		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 checked="" type="checkbox"/> NO <input 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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 <u>1-16-61</u> to <u>1-27-61</u> and last saw her/him alive on <u>1-20-61</u> Death occurred at <u>7:35 AM</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Marjorie Richardson DO</u>		22b. ADDRESS <u>9553 Larchland Rd St. Louis</u>	22c. DATE SIGNED <u>1-21-61</u>
23a. BURIAL CREMATION REMOVAL (Specify) <u>Urn</u>	23b. DATE <u>1/23/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARCUS MEMORIAL PARK</u>	23d. LOCATION (City, town or county) (State) <u>MADISON COUNTY, MO.</u>
24. FUNERAL DIRECTOR <u>Wittlauson - FREDERICKTOWN MO</u>	25. DATE RECD. BY LOCAL REG. <u>1-21-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Mungley M.D.</u>	

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  _____

Licensed Embalmer No. 4351

P. O. Address FREDERICKTOWN

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.