

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005858

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 34

AMENDED

FILED VS FEB 24 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1203 Broadway</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1203 Broadway</u> 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>Harrison</u> Last <u>Killian</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	B. DATE OF BIRTH <u>26 Oct 87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rural Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>
13a. FATHER'S NAME <u>Franklin Killian</u>		13b. MOTHER'S MAIDEN NAME <u>Callie Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>Mable McDuffie Killian</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes! WWI</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>1203 Broadway</u> <u>Mrs. W.H. Killian, Chillicothe, Mo.</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>Lumbaria Terminal</u> DUE TO (b) <u>Cerebral Hemorrhage, Recurrent</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>
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 checked="" 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>Jan 15 - 1950</u> to <u>Feb. 12 - 61</u> and last saw ^{her} him alive on <u>Feb 12 - 61</u> Death occurred at <u>1:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad M.D.</u>		22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>Feb 16 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>14 Feb 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Norman Funeral Home, Chillicothe, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 12, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Ann Marie Taylor</u>

MAR 14 1961

FEB 27 1961

MAR 28 1961

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 John P. Rodgers

Licensed Embalmer No. 4963

P. O. Address Chillicothe, Missouri

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.