

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-61-017922  
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 276

FILED MAY 31 1961

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		c. CITY OR TOWN <b>Independence</b>	
Length of stay in 1b <b>6 Yrs</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>131 E. Jones St.</b>		d. STREET ADDRESS (If outside, give location) <b>131 E. Jones St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA HESTER KILBOURN</b>	4. DATE OF DEATH Month Day Year <b>May 23 1961</b>
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5. SEX <b>Fe</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>Sept. 12 1907</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Green Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>James S Edwards</b>	13b. MOTHER'S MAIDEN NAME <b>Adelia Hopkins</b>	14. NAME OF HUSBAND OR WIFE <b>Willis Kilbourn</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Willis Kilbourn Indep. Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Bleeding Varices of Esophagus &amp; Stomach</b>	<b>1 yr</b>
	DUE TO (c) <b>Metastatic Carcinoma of liver</b>	<b>7 yrs.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Breast</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from <b>Apr 20 1961</b> to <b>May 23 1961</b> and last saw her <b>May 23 1961</b> Death occurred at <b>9:55 P.m.</b> on the date stated above, and to the best of my knowledge from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Ruth V. Andrews D.O.</b>	22b. ADDRESS <b>Independence Mo.</b>	22c. DATE SIGNED <b>5/25/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 27 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City of Centralia</b>	23d. LOCATION (City, town, or county) (State) <b>Centralia Mo.</b>
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24. FUNERAL DIRECTOR <b>Ott &amp; Mitchell,</b>	ADDRESS <b>Indep., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-27-61</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 Henry S. Mitchell  
Licensed Embalmer No. 3925

P. O. Address Indep Mo

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.