

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040736

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1076 D

STATE FILE NUMBER

AMENDED

FILED NOV 21 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in lb <u>3 yrs.</u>		c. CITY OR TOWN <u>Springfield</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Protest. Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>2619 E. Stanford</u>	

3. NAME OF DECEASED (Type or print) First <u>Barney</u> Middle <u>M.</u> Last <u>Kilhatrick</u>			4. DATE OF DEATH Month <u>November</u> Day <u>5</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"/>	8. DATE OF BIRTH <u>1-14-1903</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-farm implements</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Implements dealer</u>		11. BIRTHPLACE (City and state or country) <u>Lawrence, Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Samuel Allen Kilhatrick</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kelly</u>	
14. NAME OF HUSBAND OR WIFE <u>Winona Kilhatrick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT Address <u>Winona Kilhatrick, Springfield, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u> </u> DUE TO (c) <u> </u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic lymphatic leukemia</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	
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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 <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 1957 to 11-5-61 and last saw ^{her}him alive on 11-5-61
 Death occurred at 12:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>11-20-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bohivor Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>	

DOCUMENT

MEDICAL CERTIFICATION

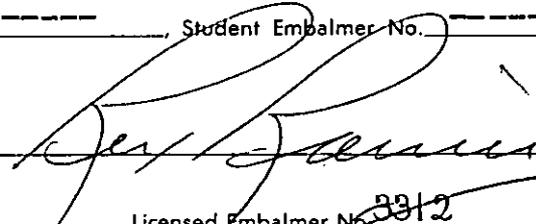
BY AFFIDAVIT OF

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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. 3312

P. O. Address Springfield, M

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.