

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-030489

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 93

Primary Registration District No. _____

Registrar's No. 62-49

STATE FILE NUMBER

FILED SEP 4 1962

VS 300
Rev. 4/59

10290
30290

3
4 0
5 2
6
7 0
8 0
97955
10
11
1290-3
131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON
W.R. Allison; Coroner

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Greenfield Mo</u>		Length of stay in 1b <u>yrs</u>	c. CITY OR TOWN <u>Greenfield Mo.</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>Home N Side Squire</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>N Side Squire</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Chester Thomas Killingsworth</u>			4. DATE OF DEATH Month Day Year <u>Aug. 12 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 1885</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>	11. BIRTHPLACE (City and state or country) <u>Dade Co Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>usa</u>		13a. FATHER'S NAME <u>Glover Killingsworth</u>	
13b. MOTHER'S MAIDEN NAME <u>Cordia Killingsworth</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>	
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>[redacted]</u>	17. INFORMANT Address <u>Elizabeth Hargis Greenfield #40</u>
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had been patient at Ellis Fisher Hospital</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 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>after death</u> and last saw her/him alive on _____ Death occurred at <u>8:00a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W.R. Allison Coroner</u>		22b. ADDRESS <u>Greenfield Mo</u>	22c. DATE SIGNED <u>8-12-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 14 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Grove</u>	23d. LOCATION (City, town, or county) <u>Dade Co Mo</u> (State)
24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/29/1962</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canaha</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 W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Georgetown

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.