S. No. 2
M—8-43
. 5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21504

State File No.

Registration District No. 336 Primary Registration District No. 6124 Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Rural Buckeye Twp

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon 101

(c) City or town Rural Buckeye Twp 0

(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James N. Kile

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M 0 | 5. Color or race W | 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Effa A Kile

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Apr (Month) 25 (Day) 1861 (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Kile
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Caroline Suggs
15. Birthplace (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Roy Kile
(b) Address Winona Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof 6-25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Reed Cemetery

18. (a) Signature of funeral director None
(b) Address —

19. (a) 6-24-45 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
year 1945 hour 7 minute 30 A M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Stomach	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Frank Hyde O (M. D. or other)
Address Commerce Date signed 6-[illegible]-45

744 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5
District File Number 745-3-34
Date Filed 7/12/45

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.