N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Buchanan

Township Agency
or
Village
or
City (NO. , St.: Ward)

Registration District No. 80 File No. 40578

Primary Registration District No. 5117 Registered No. 37

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hamilton P. King

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED — yes WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Dec (Month) 16th (Day), 1846 (Year)

AGE: 71 yrs. — mos. 5 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): 108 95

BIRTHPLACE (City or town, State or foreign country): North Carlina

PARENTS

NAME OF FATHER: Paul King

BIRTHPLACE OF FATHER (City or town, State or foreign country): North Carlina

MAIDEN NAME OF MOTHER: Martha McCombs

BIRTHPLACE OF MOTHER (City or town, State or foreign country): North Carlina

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James L. King

(ADDRESS) Agency Mo

Filed 12/22/17 191__ R. F. Donald REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: December (Month) 21 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from December 19th, 1917, to December 21st, 1917, that I last saw him alive on December 21, 1917, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 2 ds.

Contributory (SECONDARY) acute dilatation of Right Ventricle

(Duration) 10 yrs. 0 mos. 0 ds.

(Signed) Dr. S. E. Meeney M. D.

Dec. 22, 1917 (Address) Agency Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Agency Cem

DATE OF BURIAL: 12/23/17 191__

UNDERTAKER: Brown & Sons

ADDRESS: Agency Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD