

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

28617

PLACE OF DEATH
County Andrew
Township Lincoln
or Lincoln
Village Lincoln
or
City (NO. _____) St. _____ Ward _____

Registration District No. 991
Primary Registration District No. 4557

File No. _____
Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]
W 3104

FULL NAME Samuel C. King

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
DATE OF BIRTH <u>July 3, 1878</u> <small>(Month) (Day) (Year)</small>		
AGE <u>72</u> yrs. <u>2</u> mos. <u>11</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Blacksmith</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Lincoln Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Carson King</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Nancy Humphrey</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>North Carolina</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
September 14, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1920, to Sep. 14, 1920, that I last saw him alive on sep 14, 1920, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH was as follows:
Asthma and Emphysema of mitral valve and hypertrophy of heart
Asthma (Duration) 50 yrs. 6 mos. 11 ds.
Contributory Drapsy (Duration) 6 yrs. 6 mos. 11 ds.

(Signed) W. M. A. M. D.
Oct 2, 1920 (Address) Lincoln 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas C. King
(ADDRESS) Lincoln Mo.
Filed Oct 6, 1920 W. M. A.
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Lincoln Mo

DATE OF BURIAL
Sept 16, 1920

UNDERTAKER
W. G. Granger

ADDRESS
Ladonia Mo

