

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**

Do not use this space.

35890

1. PLACE OF DEATH  
 County Wayne Registration District No. 895  
 Township Superior Primary Registration District No. 0197  
 City Myrtle King St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Myrtle King  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OF RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28-1928  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 3 0 8  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work at home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_  
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Superior, Mo.  
 10. NAME OF FATHER Arch King  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co.  
 12. MAIDEN NAME OF MOTHER Josephine Asberry  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co. Mo.  
 14. INFORMANT (Address) Arch King  
Superior, Mo.  
 15. FILED 10/21 28 Ray J Owens REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-20 28  
 17. I HEREBY CERTIFY That I am the deceased's \_\_\_\_\_  
Oct 17 28 to Oct 20 28  
 that I last saw him \_\_\_\_\_ alive on Oct 17 28, and that death occurred, on the date stated above, at \_\_\_\_\_  
 THE CAUSE OF DEATH,\* AS FOLLOWS:  
Illus Catitis  
 11 3 B (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 19. Did an operation precede death? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Roy J Owens M.D.  
10/21 28 (Address) Mill Spring Mo.  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bowling Green DATE OF BURIAL 10-21 28  
 20. UNDERTAKER None ADDRESS \_\_\_\_\_

