

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

Do not use this space.

23545

1. PLACE OF DEATH

County Scott Registration District No. 821
Township Richland Primary Registration District No. 6070
City Sikeston (No.) St. Ward)

File No. 72
Registered No.
St. Ward)

2. FULL NAME Amanda 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 OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. F. King

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22, 1931

7. AGE YEARS 72 MONTHS 7 DAYS 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Galeonda
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Drew Flannery

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER unkn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Upshur
(STATE OR COUNTRY).....

14. INFORMANT C. C. Buchanan
(Address) Sikeston, Mo.

15. FILED 7/10/19 Walter Skiles
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25, 1929

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1929, to June 25, 1929, that I last saw her alive on June 25, 1929, and that death occurred, on the date stated above, at 8:30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular insufficiency of heart
9 1/2 yrs (duration) yrs. mos. ds. 4 hrs

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? PAW
IF NOT AT PLACE OF BIRTH?.....

DID AN OPERATION PRECEDE DEATH? N.O. DATE OF.....

WAS THERE AN AUTOPSY? no

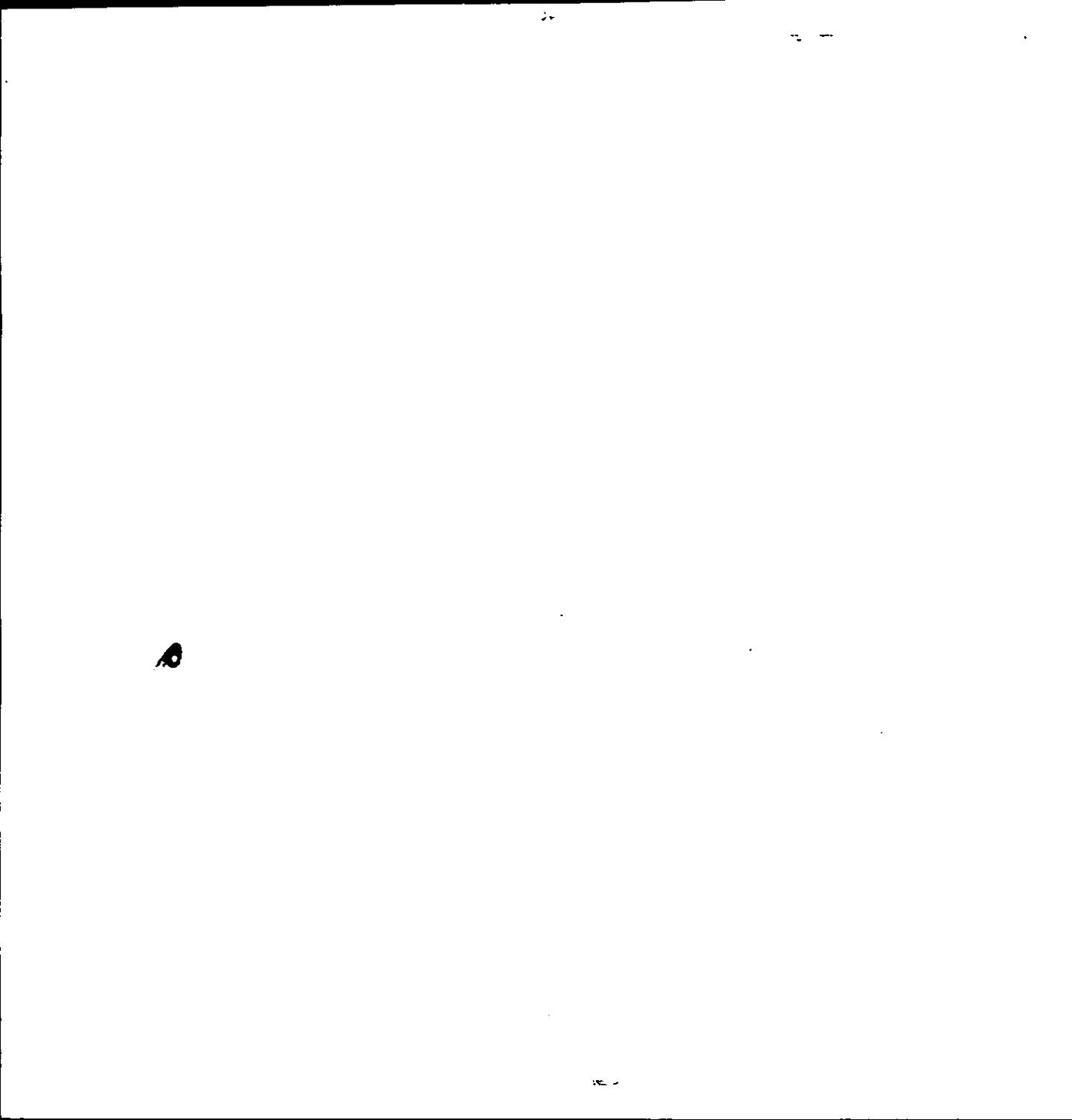
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. H. Mayfield, M. D.
Sikeston Mo, 1929 (Address)

*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 cemetary near Galeonda, Ill. DATE OF BURIAL 6-20-29

20. UNDERTAKER H. R. Dempster ADDRESS Sikeston, Mo.

4029
1929
255
2



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott Registration District No. 821 File No. 72
Township Richland Primary Registration District No. 6070 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Amanda 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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22 - 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 7 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

14. INFORMANT _____
(Address) _____

15. 710 29th St. St. Louis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-23545