

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

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.

JUN 24 1935

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

Do not use this space.

16962  
43

1. PLACE OF DEATH  
 County Lafayette Registration District No. 461  
 Township \_\_\_\_\_ Primary Registration District No. 3024  
 City Lexington (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2. FULL NAME Caroline 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) George F. King

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 15, 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>88</u>	<u>1</u>	<u>2</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME Edward Leichenring

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Dont Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Geo. W. King  
(ADDRESS) Lexington, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Lexington, Mo. DATE May 18 1935

19. UNDERTAKER (ADDRESS) Winkler, Lexington, Mo.

20. FILED May 18 1935 Jays 13-15ates  
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17, 1935

22. I HEREBY CERTIFY, That I attended deceased from May 12, 1935, to May 17, 1935.  
 I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia  
Degenerative Myocarditis  
Arterio Sclerosis  
 Date of onset \_\_\_\_\_

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) W. H. Hays, M. D.  
 (Address) Lexington Mo.

