

REC'D FEB 28 1939

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

4100
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 834
 (b) Township St. Louis Primary Registration District No. 6097
 (c) City Bloomfield R. 1 (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Oliver King
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 6 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 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) Missouri

FATHER 13. NAME Kelso

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know

MOTHER 15. MAIDEN NAME Dont know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont know

17. INFORMANT (ADDRESS) Carl King
Bloomfield R. 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Gravel Hill DATE 1-4-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. A. Chiles
Bloomfield

20. FILED 2/6 1939 D. S. McFee Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2nd 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-31-38, 1938, to 1-2-, 1939.

I last saw him alive on 1-2-, 1939. Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

Double Lobar Pneumonia
Chronic Paralysis
Nephritis
 Date of onset 10/8

Other contributory causes of importance:
Chronic Paralysis
Nephritis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

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? Yes
 If so, specify _____
 (Signed) S. S. Plavin, M. D.
Dexter (Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MEMORANDUM TO OFFICE OF PUBLIC HEALTH
CONTAINING DATA TO BE USED
IN THE DEPARTMENT OF HEALTH

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.