

1939 MAR 13

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

4687
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City (d) Street No. *Overidge Hospital* 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.

Registered No. **1380**

2. PRINT FULL NAME **530 Louvino L. O. King**

(a) Residence, No. **2340 Whitmore Pl** St. **23** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 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 **John Walter King**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 13, 1882**

7. AGE YEARS **56** MONTHS **2** DAYS **28** IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as 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) **Maquon Co., Ill.**

FATHER 13. NAME **Samuel Haizlip**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Maquon Co., Ill.**

MOTHER 15. MAIDEN NAME **Candice Farris.**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Wayne Co., Ill.**

17. INFORMANT (ADDRESS) **John Walter King**
2340 W. Whitmore Place S. E.

18. BURIAL, CREMATION, OR REMOVAL PLACE **Kenia Ill.** DATE **2-14-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Edgar D. Hamesch**
Flores & Seemins

20. FILED **FEB 12, 1939** **J. D. Bueloch** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 11, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Feb. 1, 1939** to **Feb. 11, 1939**

I last saw h. e. x. alive on **Feb. 11, 1939**. Death is said to have occurred on the date stated above, at **8:30** p. m.

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

Myocarditis - Chronic Date of onset **?**

Other contributory causes of importance:
Gangrene from embolus (left leg & foot)

Name of operation **Amputation - Rt. thigh** Date of **2/8/39**

What test confirmed diagnosis? **Clinical** Was there an autopsy? **No**

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? **No**

If so, specify **Pierce W. Powers** M. D.

(Signed) **Pierce W. Powers** (Address) **2531 80 Jefferson**

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.

Powers, Premant
3671 LAURETTE

Dr. 0549

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 *Robert S. Koff*

Licensed Embalmer No. *2971*

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.