

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1006

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. Gen. Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 11 days
(Specify whether
In this community 2 Years
years, months or days)

3. (a) PRINT FULL NAME ALFRED C. KING 520

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Mar.

6. (b) Name of husband or wife Rose King 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Sept. 24th 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 5 15 hr. min.

9. Birthplace Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Miner

11. Industry or business

MOTHER FATHER
12. Name James King
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Esther Hughes
15. Birthplace Indiana.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rose King
(b) Address 6101 Park

17. (a) Removal (b) Date thereof Mar 9 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Epiphany M.D. by Don Tetrick

18. (a) Signature of funeral director Epiphany M.D. by Don Tetrick
(b) Address Epiphany M.D. by Don Tetrick

19. (a) Mch 10, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. K.C. General Hospital No. 1
6101 Park (Residence)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th
year 1940 hour 4 minutes 15 A. M.

21. I hereby certify that I attended the deceased from 1-27-40, 19____, to 3-9-40, 19____;
that I last saw him alive on 3-9-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Benign prostatic hypertrophy with
gangrenous cystitis and ascending
pyelonephritis

Due to 10.7%
Hypostatic bronchopneumonia
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy See above
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 1

23. Signature P. G. De Maria M.D. (M. D. or other)
Address Supt. K.C. Gen. Hospital, K.C. Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FORM 1-1-1931

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.

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..... *Don Tetrick*

Licensed Embalmer No. *4008*

P. O. Address..... *Joplin Mo*

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.