

Registration District No. 182

Primary Registration District No. 5952

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Christian  
 (b) City or town Rural - Linncoln Twp  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME James Robert King

3. (b) If veteran  name war \_\_\_\_\_  
 3. (c) Social Security No. 520

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

6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April - 28 - 1940  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 4  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Clinton King

13. Birthplace Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Lois Irene Meritt

15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinton King  
 (b) Address Cleves Mo.

17. (a) Burial (b) Date thereof May 1 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frazier Chapel

18. (a) Signature of funeral director J.H. Mumper  
 (b) Address Cleves Mo.  
 19. (a) May 9, 1940 (b) Herta Nicks  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Christian  
 (c) City or town Rural  
(If outside city or town limit write "RURAL")  
 (d) Street No. Cleves Mo. R#1.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1  
 year 1940 hour 7 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from April 28, 1940  
 \_\_\_\_\_, 19\_\_\_\_, to April 30, 19\_\_\_\_.

that I last saw him alive on April 30, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Malnutrition ✓

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Refused by parents

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? 168  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. F. Cooper (M. D. or other) 1  
 Address Cleves, Mo. Date signed 5/1/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 640-1358

Date Filed JUN 10 1940

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**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.

No. 2B  
2-21-47  
I X 100

LVA MOORE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 18160

Registration District No. 182

Primary Registration District No. 5252

Registrar's No.

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

1. PLACE OF DEATH

(a) County Christian

(b) City or town Sumner T.P.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME James Robert King

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>4</u>	hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 1 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration \_\_\_\_\_

Due to toxic-intestinal defect probably typhoid fever.

Due to antibiotics requested by both parents and the doctor.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Refused by parents

157A

PHYSICIAN \_\_\_\_\_

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 \_\_\_\_\_

23. Signature G. F. Cooper (M. D. or other) \_\_\_\_\_

Address Clever Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

