25834

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 605 Primary Registration District No. 4357 Registrar's No. _____

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Gilbourn Rt 1
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town Gilbourn Rt 1
(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.

3. (a) PRINT FULL NAME Walter Wesley King Jr
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 S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June (Month) 20 (Day) 1926 (Year)

8. AGE: Years 14 Months 1 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ark 1 (State or foreign country)
10. Usual occupation nil
11. Industry or business
FATHER 12. Name Walter King, Sr.
13. Birthplace _____ (City, town, or county) Tenn (State or foreign country)
MOTHER 14. Maiden name Elsie Semore
15. Birthplace _____ (City, town, or county) Ark (State or foreign country)
16. (a) Informant's own signature [signature]
(b) Address Gilbourn Rt 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-40 (Month) (Day) (Year)
(c) Place: burial or cremation Near Blythesville, Ark
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 7/29/40 (Date received local registrar) (b) Dr. Geo W Husted (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 194 hour 10 minute 50 9 M.
21. I hereby certify that I attended the deceased from July 18, 1940, to July 29, 1940; that I last saw him alive on July 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro spinal meningitis
Due to Infection of old mastoiditis
Due to Probably B. Staph.
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____ Of autopsy _____

Duration

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? 5 3 4 (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Geo W Husted (M. D. or other)
Address Parma, Mo Date signed 7/29/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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