

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27965**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **863**

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2507 So 9th Street **2**
(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 **570**

3. (a) PRINT FULL NAME Charles Woodson King

3. (c) Social Security No. 495-018245

3. (b) If veteran, name war _____

4. Sex male

5. Color or race N

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

6. (b) Name of husband or wife Elysheth King

6. (c) Age of husband or wife if alive years _____

7. Birth date of deceased May 27 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>2</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation laborer

11. Industry or business county

MOTHER FATHER {

12. Name Hamilton King

18. Birthplace North Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Davies

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

16. (a) Informant J. L. King

(b) Address Agency, Mo.

17. (a) Burial (b) Date thereof Aug 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Agency, Mo.

18. (a) Signature of funeral director Edith Bullard

(b) Address Agency, Mo.

19. (a) Aug 7 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2507 So 11th St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 1940 hour 1100 minute P.M.

21. I hereby certify that I attended the deceased from Aug 6, 1940, to Aug 6, 1940
that I last saw him not alive alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to _____

Due to none

Other conditions none
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy no autopsy

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? _____

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

23. Signature [Signature] (M. D. or other) no
Address Agency, Mo. Date signed 8-7-40

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

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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

F. A. Sullivan

Licensed Embalmer No. *1738*

P. O. Address *Lewiston, Me.*

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.