

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

44201
Do not use this space.

1. PLACE OF DEATH **JAN 22 1941 Webster**
 (a) County **Webster** Registration District No. **896**
 (b) Township **South Hart** Primary Registration District No. **6199**
 (c) City _____ (d) Street No. _____ Registered No. **55**
 or _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred **2** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **William Lawson King**
 (a) Residence, No. _____ St. (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 **M** 4. COLOR OR RACE **wh** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Divorced**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 17 - 1868**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	72	8	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

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) **Mo. 0**

FATHER

13. NAME **B. H. P. King** **Mo. 0**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME **Adeline Briggsby** **Mo.**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Penn.**

17. INFORMANT (ADDRESS) **N. W. King**
Marshfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE **Welsh** DATE **Nov. 22** 19**41**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **M. Mahan Funeral Service**
Marshfield Mo.

20. FILED **Jan 9** 19**41** **Elycie's Highley** **Mo.**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 21** 19**40**

22. I HEREBY CERTIFY, That I attended deceased from **Nov 10** 19**40**, to **Nov 21** 19**40**
 I last saw him alive on **Nov 21** 19**40** Death is said to have occurred on the date stated above, at **5** p. m.
 The principal cause of death and related causes of importance were as follows:
Right Labor
Phumia fever
 Date of onset _____

Other contributory causes of importance: **10h**

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____
 (Signed) **W. Schmitt** M. D.
 (Address) **Newport Mo.**

M. 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.

RECEIVED
District Health Officer No. 6,
District File Number 111-128
Date Filed JAN 16 1941

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44201

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 896

Primary Registration District No. 6199

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Southavant
(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 Wm Lawson 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 DW

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 _____ hr. _____ min.
72 8 4

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

10. Usual occupation _____

11. Industry or business Farmer

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-20-71 (b) E. L. H. H. H.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster

(c) City or town Punch
(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 7 day 21
year _____ 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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 W. F. Schlicht (M. D. or other) _____

Address Manqua Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

