

JAN 21 1941

Registration District No. 604

Primary Registration District No. 4358

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution No  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 No  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JIM KING

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

4. Sex M 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife BELL KING 6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased (Month) 3 (Day) 10 (Year) 1897

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>10</u>	<u>21</u>	hr. min.

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

10. Usual occupation Day Worker on Farm

11. Industry or business No  
12. Name George King  
13. Birthplace Unk Miss.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unk  
15. Birthplace Unk Unk  
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Farmer  
(b) Address New Madrid Mo.

17. (a) Burial (b) Date thereof 1-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Madrid, Mo

18. (a) Signature of funeral director Richard W. Cello  
(b) Address New Madrid Mo

19. (a) 1-3-1941 (b) Wm O Bauson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Reynolds  
(c) City or town State  
(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 Jan day 1  
year 1941 hour 12:18 minute P.M.

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

Immediate cause of death only saw  
The man just before  
death. Kind. Preperant's  
Due to was the direct cause

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? 533  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J B W. Cello (M. D. or other) D  
Address State Mo Date signed \_\_\_\_\_

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

72  
4  
0

109

82,000  
1-15-11  
P. O. Box 100

**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.....

*Leo Hedgicott*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Leo Hedgicott*

Licensed Embalmer No. *3803*

P. O. Address *Miss Modic, M*

**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. 3537

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 604

Primary Registration District No. 4358

Registrar's No. ....

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid  
(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 Jim King

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

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

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 53 Months 10 Days 21 If less than one day..... 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.

DECEASED CERTIFICATION

20. DATE OF DEATH Month Jan day 1 year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death only saw the man just before death and pneumonia was due the direct cause of death

Due to..... N. M. D.

Other conditions..... (Include pregnancy within 3 months of death) 104

Major findings: Of operations.....

Of autopsy.....

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 J. P. McDaniel (M. D. or other).....

Address St. Louis Mo Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

111: 14

