

V. S. No. 2
 FORM 9-4-43
 Rev. 5-17-49
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28257

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 721

Registration District No. 128 Primary Registration District No. 2000

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

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burgess Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days (Specify whether _____)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Christian
 (c) City or town Cleaver, Missouri
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME DAVID HOWARD KING
 3. (b) If veteran, name war None
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month August day 31
 year 1943 hour 6 minute 22 P.M.
 21. I hereby certify that I attended the deceased from August 29
 _____, 1943, to Aug 31, 1943
 that I last saw h.i.m. alive on August 31, 1943
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None
 6. (c) Age of husband or wife if alive XX years
 7. Birth date of deceased August 29 1943
 (Month) (Day) (Year)

Immediate cause of death
① Congenital heart disease
② Prematurity
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) 1572

8. AGE: Years Months Days If less than one day
0 0 2 _____ hr. _____ min.
 9. Birthplace Springfield Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Baby

PHYSICIAN
 Major findings: Of operations _____
 Of autopsy Patent foramen ovale
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name J. Victor King
 13. Birthplace Claremore Oklahoma
 (City, town, or county) (State or foreign country)
 14. Maiden name Grace Murphy
 15. Birthplace Shelbyville Indiana
 (City, town, or county) (State or foreign country)
 16. (a) Informant J. Victor King
 (b) Address 111 Lenox Wood, Mo.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3, 43
 (Month) (Day) (Year)
 (c) Place: burial or cremation Delaware cem
 18. (a) Signature of funeral director J. H. Maples
 (b) Address Cleaver, Mo.
 19. (a) 9-1-43 (Date received local registrar) (b) J. W. Haudley (Registrar's signature)

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) Means of injury _____
 Signature Edgar L. Engel (M. D. or other) _____
 Address O'Reilly Gen Hospital Date signed 8-25-43

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.

not embalmed
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, fact should be so stated above.