

FILED DEC 17 1943

Registration District No. 200

Primary Registration District No. 5728

Registrar's No. 100

1. PLACE OF DEATH:

(a) County MACON
(b) City or town Rural - Round Grove
(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 ENTIRE LIFE (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County MACON
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Round Grove township
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John King
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 13
year 1943 hour _____ minute 59 A.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY-30 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 8
1940 to Nov 13, 1943
that I last saw him alive on Nov 1, 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 7 Days 13 If less than one day _____ hr. _____ min.

Immediate cause of death Chronic myocarditis Duration 5 yrs
Due to Chronic nephritis 8 yrs

9. Birthplace MACON County MO
(City, town, or county) (State or foreign country)
10. Usual occupation FARMER

Due to prostate obstruction 10 years
Other conditions _____
(Include pregnancy within 3 months of death)

MOTHER FATHER
11. Industry or business _____
12. Name JAMES King
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name MARY ELIZ ARBUCKLE
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: 1318
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant PRESTON V. WALKER
(b) Address CLARENCE, Mo.
17. (a) BURIAL (b) Date thereof 11-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation Bethlehem Mason Co
18. (a) Signature of funeral director C. E. Haffner
(b) Address Clarence, Mo.
19. (a) 12/30/43 (b) Clara B. Hinchler
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury MD
23. Signature Clarence M. Walker (M. D. or other) MD
Address Clarence Mo Date signed 11-19-43

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

RECEIVED

District Health Officer No. 10

District File No. 12-43-1976

Date Filed DEC 4 1943

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..... *Louis E. Hopper*

Licensed Embalmer No. 4266

P. O. Address..... Clarence, Mo.

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.