S. No. 2
1—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10063

Registration District No. 383 | Primary Registration District No. 5655 | Registrar's No. 29

1. PLACE OF DEATH:
(a) County: Lawrence
(b) City or town: Mt. Vernon, Tole. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 49 days (Specify whether years, months or days)
In this community 49 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Gideon (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: John Sherman King
3. (b) If veteran, name war: X
3. (c) Social Security No.: X
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced
6. (b) Name of husband or wife: Not Known
6. (c) Age of husband or wife if alive: X years
7. Birth date of deceased: Jan. (Month) 11 (Day) 1921 (Year)

8. AGE: Years	Months	Days	If less than one day
24	1	27	hr. min.

9. Birthplace: Gideon, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Sherman King, Sr.
FATHER 13. Birthplace: Rockford, Ohio (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Lena Clifton
MOTHER 15. Birthplace: Clifton, Tenn. (City, town, or county) (State or foreign country)
16. (a) Informant: E. McMichael, Clerk
(b) Address: Mo. State San., Mt. Vernon, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Mch 11 - 194X (Month) (Day) (Year)
(c) Place: burial or cremation: Removed Piggott Arkansas
18. (a) Signature of funeral director: Geo. B. Orr
(b) Address: Mt Vernon Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th year 1945 hour 6:00 minute P. M.
21. I hereby certify that I attended the deceased from 1-21-1945, 19__, to 3-10-, 1945; that I last saw him alive on March 10, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Failure of heart	5 years
Due to: Pulmonary Tuberculosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: Charles A. Brasher M. D. or other
Address: Mt. Vernon, Mo. Date signed 2-10-45

1338

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 445-384
Date Filed APR 2 1945

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 Geo. B. Orr

Licensed Embalmer No. 946

P. O. Address Mt Vernon 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.

No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 383 Primary Registration District No. 5655 Registrar's No.

1. PLACE OF DEATH:
(a) County: Lawrence
(b) City or town: Mt Vernon Twp.
(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 years, months or days) In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: John S. 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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan (Month) 11 (Day) 1921 (Year)
8. AGE: Years 24 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) 3-14-45 (Date received local registrar) (b) Candy Crawford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 30 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

10063