DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13609

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 33

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Washington 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
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson Co
(c) City or town Rural Grandview
(If outside city or town limits, write "RURAL")
(d) Street No. 134 & 71 Highway Grandview Mo.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gertrude King
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex female /
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife William O. King
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Jan. 20 1879 (Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 2 If less than one day hr. min.

9. Birthplace Montgomery Co. Kansas / (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Lee Larmor
13. Birthplace ? Ill. / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Bell Conrad
15. Birthplace ? Ill. / (City, town, or county) (State or foreign country)
16. (a) Informant William O. King
(b) Address Grandview, Mo R-1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Freman, Mo.
18. (a) Signature of funeral director Allen Brownfield
(b) Address Pleasant Hill, Missouri.
19. (a) 4/25/45 (Date received local registrar) (b) Dr. Annie G. Hedges (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23
year 1945 hour 1 minute A M.
21. I hereby certify that I attended the deceased from 4-15, 1943 to 4-23, 1945;
that I last saw her alive on 4-22, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	5 hours
Due to: Chronic Arteriosclerosis	3 years
Due to: Chronic Nephritis	3 years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 13/h

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 E. C. Wyckoff (M. D. or other)
Address Grand View Mo. Date signed 4-24-45

1152 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT

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

By me 2-23-55, Registered Apprentice No.

working under my personal supervision.

Signed Allen Brownfield

Licensed Embalmer No. 3785

P. O. Address Pleasant He

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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. 13609

Registration District No. 154 Primary Registration District No. 5571 Registrar's No. 33

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Washington 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 Gertrude King

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced

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 day hr. min.

9. Birthplace (City, town, or county) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 23 year 1944 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 — 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) D.O.

Address Date signed

SUPPLEMENTARY