

FILED JUN 30 1945

Registration District No. 318

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5887 Plymouth Ave.  
(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 Cecil D. King

3. (b) If veteran, name war Nil 3. (c) Social Security No. 493-10-8867

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased October 5 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 8 1 hr. min.

9. Birthplace Elsberry Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Conductor

11. Industry or business St. Louis Public Service

12. Name Joshua K. King

13. Birthplace Elsberry Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Frances Waters

15. Birthplace Elsberry Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Eula King  
(b) Address 5887 Plymouth

17. (a) Burial (b) Date thereof 6-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elsberry Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 7 1945 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5158 Easton Ave.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6  
year 1945 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from June 4  
1945, to June 6 1945  
that I last saw him alive on June 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral Hemorrhage 3 days

Due to.....

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?

While at work?..... (Specify type of place)  
(c) Means of injury.....

23. Signature J. F. Budeck (M. D. or other)  
Address 4903 Delmar Ave Date signed June 9 1945

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

00  
17  
9

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 *W. Wilkinson*

Licensed Embalmer No. *3575*

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.**