

FILED JUL 10 1945

State File No.

Registration District No. 43

Primary Registration District No. 4056

Registrar's No. 166

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Fisk
(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 2 years
In this community 2 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler
(c) City or town Fisk
(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 Benjamin H. King

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Chloe King 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased March 12 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Crittenden Co. Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER { 12. Name John Thomas King
13. Birthplace Ky.
14. Maiden name Caroline Thurman
15. Birthplace Va.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Regenia Shain
(b) Address Fisk, Mo.

17. (a) Burial (b) Date thereof 6-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)
Ash Hill

18. (a) Signature of funeral director M. Shain
(b) Address Fisk, Mo.

19. (a) 6/23/45 (b) Belle Keene
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1945 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from 4/15/42 1942 to 6/21 1945
that I last saw him alive on 6/21/45 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Respiratory Failure Duration _____

Due to Paretic Stroke
B. Lateral
Due to Hypertensive Heart Disease

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations 93A
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 _____
22. Signature Gordon Campbell M. D. or other _____
Address Fisk, Mo. Date signed 6/23/45

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

RECEIVED

District Health Office No. 2

District File Number 745-90

Date Filed 7-6-45

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 Wallace N. Fitch

Licensed Embalmer No. 3159

P. O. Address Poplar Bluff, 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.