

FILED NOV 13 1945

Registration District No. 55

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1007 N. Jefferson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll
(c) City or town Carrollton
(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

EMMA MAY KING

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

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John King 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased May 1 1895
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Cincinnati, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name James Milford
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Mary Murphy
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant John King
(b) Address Carrollton, Mo.

17. (a) Burial (b) Date thereof 10-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director Stanley Gibson
(b) Address Carrollton, Mo.

19. (a) 10/13/45 (b) Mrs. Neshiel Calvert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
year 1945 hour 8 minute 00 P. M.

21. I hereby certify that I attended the deceased from 10-6 1945 to 10-10 1945
that I last saw h. _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis with coma
Duration 10 days

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy 130
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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) (e) Means of injury _____

23. Signature W.S. Atwood (M. D. or other) _____
Address Carrollton, Mo. Date signed 10/13/45

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 11-12-46 -

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 *Ben W. Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton, W. Va.*

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.