

FILED JAN 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. **40586**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **1397**

1. PLACE OF DEATH:

(a) County **Burlington**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1806 No 2 rd 1**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **abt 60 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Burlington**
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1816 No 2 rd**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME EDITH-M- KING.

3. (b) If veteran, name war **WW** 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race _____ 6. (a) Single, widowed, married, divorced **Wid**
 6. (b) Name of husband or wife **William J. King** 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **March 13 1858**
(Month) (Day) (Year)

8. AGE: **87** Years **9** Months **11** Days If less than one day _____ hr. _____ min.

9. Birthplace **Columbus Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER
 12. Name **Wm King**
 13. Birthplace **Wm King**
(City, town, or county) (State or foreign country)
 14. Maiden name **Wm King**
 15. Birthplace **Wm King**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jessie King**
 (b) Address **St Joseph MO**

17. (a) **burial** (b) Date thereof **12/29/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Asheburd Cem.**

18. (a) Signature of funeral director **Plummer Farm Home**
 (b) Address **St Joseph MO**

19. (a) **Dec 28 1945** (b) **T. A. Witham**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **24**
 year **1945** hour **5:25** minute **P** M.

21. I hereby certify that I attended the deceased from **Nov 1st** 19**45** to **Dec 24** 19**45**
 that I last saw him alive on **Dec 23** 19**45**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**

Due to _____

Due to _____

Other conditions **Senile dementia**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy **16 2 1/2**

Duration _____
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? _____ (c) Means of injury _____

23. Signature **Roy Beck** (M. D. or other) _____
 Address **King Hill Way, ST. JOSEPH** Date signed **3/26/46**

MAR 29 1943

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.....

John Roy Stone

Licensed Embalmer No. *2435*

P. O. Address.....

St. Joseph

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

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

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1397

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St Joseph
(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)

3. (a) PRINT FULL NAME

Edith McKing

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

4. Sex F 5. Color or race WHITE 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased mar
(Month) (Day) (Year)

8. AGE: Years 87 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 _____

12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (c) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1924 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
 Immediate cause of death: _____

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) (e) Means of injury

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WHILE FLAINDI—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 29 1949