

STANDARD CERTIFICATE OF DEATH

State File No. **16269**

FILED JUN 13 1946
Registration District No. **128**

Primary Registration District No. **4198**

Registrar's No. **57**

1. PLACE OF DEATH:

(a) County Henry
(b) City or town King City, Mo.
(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 33 yrs. years, months or days

3. (a) PRINT FULL NAME Helen Belle Quiser
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Theo. C. Quiser 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Nov. 12 1904 (Month) (Day) (Year)

8. AGE: Years 41 1/2 Months 11 Days 16 If less than one day hr. _____ min. _____

9. Birthplace Albany, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation post office clerk

11. Industry or business _____

MOTHER FATHER { 12. Name James Y. Fickline
13. Birthplace Ky (City, town, or county) (State or foreign country)
14. Maiden name Leora Ross
15. Birthplace Strawberry, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Theo. C. Quiser
(b) Address King City, Mo.
17. (a) Burial (b) Date thereof May 21 1946 (Month) (Day) (Year)
(c) Place: burial or cremation King City, Mo.

18. (a) Signature of funeral director Frank W. Wilson
(b) Address King City, Mo.
19. (a) May 27 - 1946 (Date received local registrar) (b) Ronald M. Stahler (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry **38**
(c) City or town King City (If outside city or town limits, write "RURAL") **31**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? No (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18 year 1946 hour 16 minute 30 a.m.

21. I hereby certify that I attended the deceased from 1-17 to May 18 1946 and that death occurred on the date and hour stated above. **46**
that I last saw her alive on May 18 1946 **46**

Immediate cause of death Cancer of brain
Due to Cancer of uterus

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

Major findings: Of operations _____
Of autopsy 480

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 job)
(c) Means of injury _____
23. Signature E. Blacklock (M.D. or other)
Address King City, Mo. Date signed 6/20/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY REQUEST

103

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *Lucile M. Wilson*

Licensed Embalmer No. *2830*

P. O. Address *King City, 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.

Registration District No. 120

Primary Registration District No. 4198

1. PLACE OF DEATH:

(a) County Lentz
(b) City or town King City, MO
(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 _____
years, months or days

3. (a) PRINT FULL NAME Helen B. Ariser

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

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

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

7. Birth date of deceased Nov - 12 (Month) (Day) (Year)

8. AGE: Years 4 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Specify type of place)
(c) Place: burial or cremation _____

18. (a) 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 May 1948
year 1948 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 Causes of uterine

Due to _____

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

Major findings: Of operations _____ Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature E. Blacklock (M. D. or _____)
Address King City, MO Date signed 6/17/48

SUPPLEMENTARY

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

MOTHER FATHER

16269