S. No. 2
I—5-42
5-17-39
P I X32873

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

37690

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 26 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. 122

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural Hudson Twp
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61

(c) City or town Macon 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Joseph C King

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Feby 22 - 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Retired farmer

11. Industry or business

FATHER
12. Name Joseph King
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name — Whisenand
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant J C Davalt
(b) Address Ethel Mo

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof 10/2/46 (Month) (Day) (Year)
(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo

19. (a) Nov 5-46 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1946 hour 7 minute P M.

21. I hereby certify that I attended the deceased from Sev Months, 19 , to , 19 ; that I last saw him alive on Sept 27, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma Nose	Sev yrs.
Due to	
Due to	
Other conditions Metastasis (Include pregnancy within 3 months of death)	

Major findings:
Of operations 53
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 0

23. Signature Howard Miller (M. D. or other)
Address Macon Date signed 10/5/46

185

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-46-2114
Date Filed NOV 25 1946

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon

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.

. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 200 Primary Registration District No. 5725 Registrar's No. 122

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Rural
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Macon
(c) City or town: Macon-Mo Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: R. 7. D.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Joseph C. King
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased: Feb 22 1863 (Month) (Day) (Year)
8. AGE: Years 83 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. Day 30 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

37690