No. 2
5-43
X 6671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14199

State File No.

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 181

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
318a North Main St. 1
(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 Missouri (b) County Marion 64

(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")

(d) Street No. 318a North Main St. 4
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME THOMAS FRANCIS KING

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male C

5. Color or race White

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

6. (b) Name of husband or wife Mary

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

7. Birth date of deceased Jan. (Month) 13 (Day) 1892 (Year)

8. AGE: Years 55 Months 3 Days 16 If less than one day hr. min.

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

10. Usual occupation Gen Laborer

11. Industry or business

FATHER
12. Name John King
13. Birthplace (City, town, or county) England (State or foreign country) 4

MOTHER
14. Maiden name Johanna Jones
15. Birthplace (City, town, or county) Ireland (State or foreign country) 4

16. (a) Informant Mrs. Mary King
(b) Address Hannibal, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-2-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Jas O'Donnell
(b) Address Hannibal, Missouri

19. (a) 5-6-47 (Date received local registrar) (b) DV E. M. Lucke (Registrar's signature) 139

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1947 hour minute 5:00P.M

21. I hereby certify that I attended the deceased from April 4, 1947, to 29 April, 1947
that I last saw him alive on 27 APRIL, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis, pulmonary, far advanced	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

138

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 Merrill J. Poller (M. D. ~~(mother)~~)
Address 113 a S. Main Hannibal Date signed

(Licensed Embalmer's Statement on Reverse Side)

mo May 2/47

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. 497,

working under my personal supervision.

Signed W. M. A. Hannell

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.

2B
13-45
X43880

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

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STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 181

1. PLACE OF DEATH:

(a) County: Marion

(b) City or town: Hannibal
(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 (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

3. (a) PRINT FULL NAME: Thomas F. Kurig

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: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 13 (Day) 189 (Year)

8. AGE: Years 55 Months 3 Days 6 Unless than one day hr. min.

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

10. Usual occupation: Employee Gas Co.

11. Industry or business: Gen Laborer

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) (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) E. M. Luetkemeyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 194 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.

Immediate cause of death — Duration

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

Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 29

14199