S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 23 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 22398
Registrar's No. 5681

1. PLACE OF DEATH:

(a) County
(b) City or town: ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. JOHNS HOSPITAL
(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: ILL (b) County: MARION 999
(c) City or town: CENTRALIA 11
(If outside city or town limits, write "RURAL")
(d) Street No. 410 MELROSE 0
(If rural, give location)
N.R.
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME: FLOYD B. 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: MARRIED
6. (b) Name of ~~husband or~~ wife: ROSE
6. (c) Age of ~~husband or~~ wife if alive: 60 years
7. Birth date of deceased: MAR (Month) 23 (Day) 1884 (Year)

8. AGE: Years	Months	Days	If less than one day
63	2	14	hr. min.

9. Birthplace: BLYSDALE (City, town, or county) MO (State or foreign country)
10. Usual occupation: FOREMAN C.B.Q. RR.
11. Industry or business:

FATHER
12. Name: CHARLES KING
13. Birthplace: UNKOWN (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: FLORENCE FOLEY
15. Birthplace: UNKOWN (City, town, or county) (State or foreign country)

16. (a) Informant: ROSE KING
(b) Address: CENTRALIA ILL.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-9-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: CENTRALIA ILL
18. (a) Signature of funeral director: ROWLAND FUNERAL HOME
(b) Address: 4355 WASHINGTON AV
19. (a) JUN 9 1947 (Date received by registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 7th year 1947 hour 3:00 minute A. M.
21. I hereby certify that I attended the deceased from 6/5/47, 19..., to 6/7/47, 19...; that I last saw him alive on 6/6/47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive heart failure	1 wk
Due to: arteriosclerotic heart disease	(2)
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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: O. Huck (M. D. or other) 2nd
Address: Hamilton Mo. Date signed 6/9/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....Rex Campbell.....

Licensed Embalmer No.....3881.....

P. O. Address....4355 Washington C

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.