No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 14 1947

Registration District No. 377

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36662

Registrar's No. 2290

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 201 days (Specify whether

In this community 15½ years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 3712 North 14th St. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME KING, JOHN

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Agnes McClain (divorced)

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

7. Birth date of deceased August (Month) 30 (Day) 1892 (Year)

8. AGE:

Years	Months	Days	If less than one day
55	2	6	hr. min.

9. Birthplace Iron County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name William Thomas King

13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER

14. Maiden name Jane Bobb

15. Birthplace (City, town, or county) Georgia (State or foreign country)

16. (a) Informant Robert Koch Hospital

(b) Address Hospital Records

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-8-47 (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Avenue

19. (a) 11-8-47 (Date received local registrar) (b) Cecil A. Sharp (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5 year 1947 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from 4-18- 1947 to 11-5- 1947; that I last saw him alive on 11-5- 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1 yr. (?)
Due to 13 b	
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 John T. Vogel (M. D. or other) M.D.

Address Robert Koch Hospital Date signed 11-6-47

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 C. W. Cooper

Licensed Embalmer No. 3830

P. O. Address 2301 Lafayette

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.