

FILED NOV 25 1947

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 40710

Registration District No. 360

Primary Registration District No. 6228

Registrar's No. 172

1. PLACE OF DEATH:

(a) County Vernon  
(b) City of Washington Strop.  
(If outside city or town limits, write "RURAL" and name of township)  
Name of hospital or institution: State Hospital no. 32  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Several weeks  
(Specify whether  
In this community 47-9-24  
years, months or days Y M D)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon  
(c) City or town Neuada  
(If outside city or town limits, write "RURAL")  
(d) Street No. 418 W Walnut  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Little George King

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 496-05-2702

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

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

7. Birth date of deceased 1 20 1900  
(Month) (Day) (Year)

8. AGE: Years 47 Months 9 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Salmoner

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name George King  
13. Birthplace Illinois  
14. Maiden name Ada Belle Wheaton  
15. Birthplace Joving Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Eula May Roemmer  
(b) Address 419 W Walnut

17. (a) Burial (b) Date thereof Oct 26 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Allyn Hays  
(b) Address Neuada Mo

19. (a) 11-15-47 (b) Ruthie Hancy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24  
year 1947 hour 3 minute 7 P. M.

21. I hereby certify that I attended the deceased from 8-29-1947 to 10-24-1947  
that I last saw him alive on 10-24-1947  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arterio Sclerotic Heart Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 1

23. Signature Ed Bunch (M. D. or other) \_\_\_\_\_  
Address State Hospital #3 Date signed 10-24-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 71  
District No. 10-47-1347  
District No. 11-24-47  
Date Filed

**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 Allen V. Hayes  
Licensed Embalmer No. 1968  
P. O. Address Quincy, 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, above space should be left blank.