

Registration District No. 159

Primary Registration District No. 4249

State File No. ....

Registrar's No. 11

1. PLACE OF DEATH

(a) County Jefferson  
(b) City or town Hillsboro  
(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. 76 years (Specify whether years, months or days)  
In this community 76 years

3. (a) PRINT FULL NAME JOSEPH SAMUEL KING

3. (b) If veteran, name war. No 3. (c) Social Security No. —

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced. MARRIED

6. (b) Name of husband or wife Gertrude King 6. (c) Age of husband or wife if alive. 61 years

7. Birth date of deceased Feb 24 1872  
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 17 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business

MOTHER FATHER  
12. Name James King  
13. Birthplace Hillsboro Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Menden  
15. Birthplace Hillsboro Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Gertrude King  
(b) Address Hillsboro Mo.

17. (a) Burial (b) Date thereof March 14 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillsboro Mo.

18. (a) Signature of funeral director Donald B. Dinkin

(b) Address Delato Mo.

19. (a) 3/16/48 (b) Kathryn Morade  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jefferson  
(c) City or town Hillsboro  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11  
year 1948 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from March 5, 1948 to March 11, 1948  
that I last saw him alive on March 10, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death. Coronary thrombosis, with myocardial infarction. Duration 7 days  
Due to Hypertensive, arterio-sclerotic heart disease. ?

Due to .....

Other conditions (Include pregnancy within 3 months of death) 93 F

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? .....

While at work? (Specify type of place) (c) Means of injury O

23. Signature Thomas A. Donnell (M. D. or other) M.D.  
Address Delato, Mo. Date signed 3-12-48

RECEIVED  
District Health Officer No. 9  
District File Number  
Date Filed MAR 24 1948

SEP 30 1950

SEP 29 1950

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 *Donnell B. Dietrich*  
Licensed Embalmer No. *4104*  
P. O. Address *Albeto 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 11

Registration District No. 15-9 Primary Registration District No. 4249

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

1. PLACE OF DEATH:

(a) County Jefferson Hillsboro  
 (b) City or town Hillsboro  
(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)

3. (a) PRINT FULL NAME Joseph S. 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 M  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Set. 24  
(Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 3-16-48 (b) Kathleen Marada  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 11  
 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

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

PHYSICIAN

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

S-9146