

No. 2  
5-5-43  
5-17-39  
I X36871

FILED MAY 7 1948

Registration District No. **949**

Primary Registration District No. **1002**

48  
3  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Oak Grove K.C. Mo**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **Trinity Lutheran Hospital**  
(If not in house or institution, write street number or location)

(d) Length of stay: **1 week** in hospital or institution (Specify whether years, months or days)

In this community **78 yrs**

3. (a) PRINT FULL NAME **Sallie King**

3. (b) If veteran, name war **-no**

3. (c) Social Security No. **-none**

4. Sex **F ml** 5. Color or race **w**

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

6. (b) Name of husband or wife

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

7. Birth date of deceased **July 10 1869**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **9** Days **29** If less than one day **hr. min.**

9. Birthplace **Oak Grove Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired school teacher**

11. Industry or business

12. Name **John King**

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

14. Maiden name **Abigail Farmer**

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

16. (a) Informant **Miss Pearl King**

(b) Address **Oak Grove Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4-21-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Mo**

18. (a) Signature of funeral director **W. B. Webb, Jr.**

(b) Address **Oak Grove Mo**

19. (a) **4-21-48** (Date received local registrar) (b) **Staldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Oak Grove Mo**  
(If outside city or town limits, write "RURAL")

(d) Street No. **6**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **19th**  
year **1948** hour **4** minute **45** A.M.

21. I hereby certify that I attended the deceased from **Pathologist**

that I last saw him **alive on** **19**  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute cardiac dilatation**

Due to **Pneumonia**

Due to **Arteriosclerotic Heart D. (hypertension)**

Other conditions (include pregnancy within 3 months of death) **arteriosclerosis**

Major findings: Of operations

Of autopsy **above**

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

23. Signature **Jacob Cordell** (M. D. or other)

Address **Trinity Lutheran Hosp.** Date **20 Apr 48**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

*Kenneth Rayen*

Registered Apprentice No. *63*

working under my personal supervision.

Signed.....

*R. B. Webb*

Licensed Embalmer No. *2353*

P. O. Address *Blue Springs 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.