

S. No. 2
1-8-43
5-17-39
X77223

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18924

FILED JUL 15 1948

Registration District No. _____

Primary Registration District No. 4107

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 2 1/2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon ¹⁰⁸
(c) City or town Schell City
(If outside city or town limits, write "RURAL") ³
(d) Street No. _____ (If rural, give location) ¹
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1948 hour 6:15 minute A. M.
21. I hereby certify that I attended the deceased from April
1948, 1948 to June, 1948
that I last saw him alive on June 13, 1948
and that death occurred on the date and hour stated above.
Immediate cause of death interstitial nephritis
Duration _____

3. (a) PRINT FULL NAME Alma King
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife George W. King 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: October 16 1874
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 0
If less than one day _____ hr. _____ min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Charles William Hudson

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

14. Maiden name Annie B. Sutton

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

16. (a) Informant Mrs. M. M. Lewis

(b) Address Schell City, Mo.

17. (a) burial (b) Date thereof: 6/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlaw Cemetery

18. (a) Signature of funeral director Lewis & Son

(b) Address Schell City, Mo.

(c) 6-17-48 (b) J.C. BADA 4021
(Date received local registrar) (Registrar's signature)

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 12/16
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) (e) Means of injury _____

23. Signature J. Dawson (M.D. or other) _____

Address El Dorado Springs, Mo. Date signed 6-16-48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 7-14-48

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 Marion M. Lewis

Licensed Embalmer No. 3084

P. O. Address Schell city, 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.

Registration District No. 61 Primary Registration District No. 4107

1. PLACE OF DEATH:
 (a) County Cedar
 (b) City or town Clearcreek Springs
 (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 (Specify whether _____)

3. (a) PRINT FULL NAME Alma King
 3. (b) If veteran, name war _____ (c) Social Security No. _____

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

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

7. Birth date of deceased Oct 16 (Month) 16 (Day) 1946 (Year)

8. AGE: 73 Years 8 Months 8 Days (If less than one Day _____ hr. _____ min.)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) MO

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 6-17-48 (Date received local registrar) (b) J. H. Brannon (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 _____ Year 1946 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 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)

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 _____
 23. Signature _____ (M. D. or other) _____
 Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-18 724