

FILED MAR 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5129

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5573 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Grain Valley		c. CITY (If outside corporate limits, write RURAL and give township) Grain Valley	
c. LENGTH OF STAY (In this place) 50 yrs		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) John b. (Middle) W c. (Last) King			4. DATE OF DEATH (Month) (Day) (Year) Feb. 10. 50
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 5-1868
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) Retired Station Operator	11. BIRTHPLACE (State or foreign country) Atlanta Ga.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME James W King		13b. MOTHER'S MAIDEN NAME Abelene Martin	14. NAME OF HUSBAND OR WIFE Effie King
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Effie King Grain Valley Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia INTERVAL BETWEEN ONSET AND DEATH 72 hrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer (skin type) abt 45 yrs DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19 IX	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan. 15, 1950, to Feb. 10, 1950, that I last saw the deceased alive on Jan. 9, 1950, and that death occurred at 2:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Charles Himmeler, M.D. (Degree or title)		23b. ADDRESS Grain Valley	23c. DATE SIGNED 2-11-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Feb 12-50	24c. NAME OF CEMETERY OR CREMATORY Oak Grove	24d. LOCATION (City, town, or county) (State) Oak Grove Mo
DATE REC'D BY LOCAL REG. 2-13-50	REGISTRAR'S SIGNATURE Donald C. Carnahan 1378	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs GB Witt Son Oak Grove Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 23 RECD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed RB Webb

Licensed Embalmer No. 2353

P. O. Address Blue Spring Ma

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.