

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **12093**

BIRTH MO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>5132</u>		Registrar's No. <u>497</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural Wayne Twsp.</u>) c. LENGTH OF STAY (in this place) <u>15 yrs.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rt. # 1, Halls</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>0110</u> OR TOWN <u>Rural Wayne Twsp.</u> d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 1, Halls, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSA</u> b. (Middle) <u>LEE</u> c. (Last) <u>KING</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4- 22 1950</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3-6-1875</u>		9. AGE (in years) <u>75</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 10 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky /</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Allen B. Porter</u>	
13b. MOTHER'S MAIDEN NAME <u>Malinda Stewart</u>		14. NAME OF HUSBAND OR WIFE <u>Charles King</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Charles King, Rt. # 1, Halls, Mo.</u>		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, asphyxia, etc. It means the disease, injury, or complication which caused death. 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 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) 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 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 <u>4-3-50</u> , to <u>4-22-50</u> , that I last saw the deceased alive on <u>4-22-1950</u> , and that death occurred at <u>7:40P</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Benjamin M. Riley M.D.</u> (Degree or title)		23b. ADDRESS <u>822 E. 1st St. St. Joseph, Mo.</u>		23c. DATE SIGNED <u>4-23-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-27-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>			
24d. LOCATION (City, town, or county) (State) <u>DeKalb, Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph E. Rupp</u> ADDRESS <u>St. Joseph, Misso</u>		DATE REC'D BY LOCAL REG. <u>April 26, 1950</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.