S. No. 300
v. 10.48

OCT 6 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33966
33

State File No.

BIRTH NO. REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No.

1050
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1. PLACE OF DEATH
a. COUNTY: Sullivan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milan
c. LENGTH OF STAY (in this place): 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wallace Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Sullivan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milan 1050
d. STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print): a. (First) HENRY b. (Middle) SYLVESTER c. (Last) KING

4. DATE OF DEATH (Month) (Day) (Year): Sept 24 1952

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 21 1870

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mercer Co Mo

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Greenburg King

13b. MOTHER'S MAIDEN NAME: Minerva Sanders

14. NAME OF HUSBAND OR WIFE: Unknown

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: Earl King — **ADDRESS**: Osgood 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) Pulmonary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Complained of cold for 3 days.
DUE TO (c)

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: 470X

20. AUTOPSY? YES ☐ NO ☒

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) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-24, 1952, *to* 9-24, 1952, *that I last saw the deceased alive on* 9-24, 1952, *and that death occurred at* 1:05p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Simpson M.D.

23b. ADDRESS: Milan, Mo.

23c. DATE SIGNED: 9-25-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-27-52

24c. NAME OF CEMETERY OR CREMATORY: Topsy Cem

24d. LOCATION (City, town, or county) (State): Spickard Mo.

DATE REC'D BY LOCAL REG.: 9-28-52

REGISTRAR'S SIGNATURE: Mrs. H. B. Harris

25. FUNERAL DIRECTOR'S SIGNATURE: P K Payne Son — **ADDRESS**: Galt Mo

(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 P A Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.