

FILED DEC 28 1954

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40384**

BIRTH NO. _____ REG. DIST. NO. **65** PRIMARY REG. DIST. NO. **5253** Registrar's No. **32**

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Chariton	
b. CITY OR TOWN Snyder		c. CITY OR TOWN Snyder	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		f. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) FRANK	b. (Middle) King	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12-11-54
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 4-1875	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 8 Days 7	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) TENN	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wesley King	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Frank King Snyder	ADDRESS MO
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Medullary Anoxemia		INTERVAL BETWEEN ONSET AND DEATH approx. 2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Uremic Acidosis		
	DUE TO (c) Proxiphitis of Urinary Retention		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Massive Prostate Hypertrophy.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 6000	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-10**, 1954, to **12-11**, 1954, that I last saw the deceased alive on **12-11**, 1954, and that death occurred at **6:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE E. B. Brunston M.D.	23b. ADDRESS Mendon, Missouri	23c. DATE SIGNED 12-13-54
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 12-13-54	24c. NAME OF CEMETERY OR CREMATORY McCullough	24d. LOCATION (City, town, or county) (State) Triphett MO
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DATE REC'D BY LOCAL REG. 12-13-54	REGISTRAR'S SIGNATURE Mildred Boone	25. FUNERAL DIRECTOR'S SIGNATURE N. L. Shepard	ADDRESS Mendon MO
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(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.....
Signature of Student Embalmer

Signed.....
S. L. Lipard

Licensed Embalmer No. *397*

P. O. Address *Mendon*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.