

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14478**

BIRTH NO. _____		REG. DIST. NO. <b>365</b>		PRIMARY REG. DIST. NO. <b>6238</b>		Registrar's No. <b>7</b>		
1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN <b>Belgrade</b>		c. LENGTH OF STAY (in this place) <b>all of life</b>		c. CITY OR TOWN <b>Belgrade</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <b>1100</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Effie</b> b. (Middle) <b>Thompson</b> c. (Last) <b>King</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 13 1955</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 3 1874</b>		9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Washington Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Orlando Rowland</b>		13b. FATHER'S MAIDEN NAME <b>Louisa Mitchell</b>		14. NAME OF HUSBAND OR WIFE <b>James H. King</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>James H. King</b> ADDRESS <b>Belgrade Mo.</b>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Valvular heart lesion</b>					INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arterio sclerosis</b> <b>Hypertension</b> 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 <b>H2+4</b>				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) _____		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 <b>12-25</b> , 19 <b>54</b> , to <b>4-13</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>3-20</b> , 19 <b>55</b> , and that death occurred at <b>11:15 A.M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Joseph L. Thurman, M.D.</b>				23b. ADDRESS <b>Potosi, Mo</b>		23c. DATE SIGNED <b>4-16-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24b. DATE <b>4-15-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Caledonia M.E. Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Washington Co. Mo</b>		
DATE REC'D BY LOCAL REG. <b>4-19-55</b>		REGISTRAR'S SIGNATURE <b>Elba J. White</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Luther Spahr</b>		ADDRESS <b>Potosi Mo.</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

APR 26 1955

WASH. COUNTY HEALTH DEPT.

File No. \_\_\_\_\_

JUN 27 1955

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 *Murphy Sparks*

Licensed Embalmer No. *4236*

P. O. Address *Flat 1011 M*

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.