

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37116**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **481**

1. PLACE OF DEATH a. COUNTY-- <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>	c. LENGTH OF STAY (In this place) <b>65 years</b>	c. CITY OR TOWN <b>Independence</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Residence</b>		e. STREET ADDRESS (If rural, give location) <b>625 E. Kansas</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Maud</b> b. (Middle) _____ c. (Last) <b>King</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 29, 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 19, 1890</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Jackson County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>James Rolen</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Foster</b>	14. NAME OF HUSBAND OR WIFE <b>Walter King</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Walter King, Independence, Mo.</b>	ADDRESS _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>	DUE TO (b) <b>Hypertensive Cardiovascular disease</b>		years _____
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) _____		years _____
II. OTHER SIGNIFICANT CONDITIONS <b>Diabetes mellitus</b>	_____		yes _____
_____	_____		no _____
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>443x</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 **July, 1949**, to **11/29, 1955**, that I last saw the deceased alive on **11/27, 1955**, and that death occurred at **5 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Vance E. Lumb, M.D.</b>	23b. ADDRESS <b>129 West Lexington, Indep. Mo.</b>	23c. DATE SIGNED <b>12-1-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12/2/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>12-2-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Ho. G. Carson</b>	ADDRESS <b>Independence, Mo.</b>
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WRITE PLAINLY—USING UNEADING 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 *J. D. Gibson*

Licensed Embalmer No. *48*

P. O. Address *Indep.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.