

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3304**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **7**

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Marshall, Mo.</b>		c. CITY OR TOWN <b>Marshall</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>33Yrs.</b>		e. STREET ADDRESS (If rural, give location) <b>2Mi. South West of Marshall</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Anna</b> b. (Middle) <b>King</b> c. (Last) <b>Humphrey</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>1 - 13 - 57</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 19-1894</b>	9. AGE (In years last birthday) <b>62</b>	if UNDER 1 YEAR Months <b>11</b> Days <b>24</b>	if UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant at Mo. State School</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Sweet Springs, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thomas P. King</b>	13b. MOTHER'S MAIDEN NAME <b>Nannie Berry</b>	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) <b>No</b>	16. SOCIAL SECURITY NO. <b>500-34-3280</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Berry King-Malta Bend, Mo. R.F.D.</b>	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <del>Metastatic carcinoma of the breast</del>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Metastatic generalized carcinoma - primary left breast.</b>		
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>Mastectomy 1955 - ca breast 170X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (a.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) (Min.)	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 **Sept 1956** to **1-13, 1957**, that I last saw the deceased alive on **1-13, 1957** and that death occurred at **2:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Carl H. Head MD</b>	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>1/14/57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park</b>	24d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>1-14-57</b>	REGISTRAR'S SIGNATURE <b>Carl H. Head</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>G. LeRoy Sweeney - Marshall, Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Leslie Seymour*

Licensed Embalmer No. *7235*

P. O. Address *Wasshach*

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.