

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32823**  
Registrar's No. **53**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **264** PRIMARY REG. DIST. NO. **5892**

1. PLACE OF DEATH a. COUNTY <b>Ozark</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Ozark</b>	
b. CITY OR TOWN <b>rural - Hunt</b>	c. LENGTH OF STAY in this place <b>Life</b>	c. CITY OR TOWN <b>Jecumach</b>	d. 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		e. STREET ADDRESS (If rural, give location) <b>0770</b>	

3. NAME OF DECEASED (First) <b>Everett</b>	b. (Middle) <b>L.</b>	c. (Last) <b>King</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>9-11-57</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>3-14-1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Jecumach, Mo.</b>	9. AGE (In years last birthday) <b>74</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR.: Hours _____ Mins. _____
12a. FATHER'S NAME <b>Jah H. King</b>	13b. MOTHER'S MAIDEN NAME <b>Susan Galtbreath</b>	14. NAME OF HUSBAND OR WIFE <b>Alta Hodgson</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Clyde King, Jecumach, Mo.</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, asphyxia, 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) <b>Cerebral hemorrhage</b>		<b>6 weeks</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterial hypertension</b> DUE TO (c) _____		<b>3 yrs or more</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Prostatic hypertrophy &amp; Urinary Retention</b>		<b>3 yrs</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331x</b>		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) (Min.)	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 **2-13**, 19**54**, to **9-11**, 19**57** that I last saw the deceased alive on **9-10**, 19**57**, and that death occurred at **9:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>M. J. Haerman D.O.</b>	23b. ADDRESS <b>Gainesville, Mo.</b>	23c. DATE SIGNED <b>9-12-57</b>
24a. BURIAL / CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>9-13-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Clear Spring</b>
DATE REC'D BY LOCAL REG. <b>9/21/57</b>	REGISTRAR'S SIGNATURE <b>Thana Mahan</b>	24d. LOCATION (City, town, or county) (State) <b>Ozark County, Mo.</b>
25. FUNERAL DIRECTOR'S SIGNATURE <b>Cluckeyhead</b>		ADDRESS <b>Gainesville</b>

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 *John R. Cherry*.....

Licensed Embalmer No. *4885*.....

P. O. Address *Camden*.....

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.