

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-031913

STATE FILE NUMBER

FILED OCT 6 1958

Registration District No. 43

Primary Registration District No. \_\_\_\_\_

Registrar's No. 547

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Reynolds</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Ellington,</b> 09 00
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Poplar Bluff Hosp.</b>		Length of stay in lb <b>30 minutes</b>	d. STREET ADDRESS (If outside, give location) <b>Ellington, Mo.</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Lee</b> Last <b>King</b>			4. DATE OF DEATH Month <b>9</b> Day <b>20</b> Year <b>58</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1940</b>	9. AGE (In years last birthday) <b>18</b>	IF UNDER 1 YEAR Months _____ Days _____	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) <b>Shoemaker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Camille Design</b>	11. BIRTHPLACE (City and state or country) <b>Reynolds County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James L. King</b>	13b. MOTHER'S MAIDEN NAME <b>Dell Chitwood</b>	14. NAME OF HUSBAND OR WIFE <b>NA</b>
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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>490-40-0172</b>	17. INFORMANT <b>James L. King, Ellington, Missouri</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shoot and multiple square hit</b> <b>Auto. accidents</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Auto Accident on Highway 21, 3 mi. S. of Ellington, Mo.</b>
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20c. TIME OF INJURY Hour <b>6:40</b> Month <b>9</b> Day <b>20</b> Year <b>58</b> a.m. _____ p.m. _____	
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>On Highway</b>	20f. CITY, TOWN, OR LOCATION <b>Reynolds County, Mo.</b>	COUNTY <b>090</b> STATE
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21. I attended the deceased from **9-20-58** to **9-20-58** and last saw her/him alive on **9-20-58**.  
Death occurred at **9:30 P.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Sam S. Davis M.D.</b>	22b. ADDRESS <b>Poplar Bluff, Missouri</b>	22c. DATE SIGNED <b>9-23-58</b>
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23a. BURIAL, CREMATION, ETC. (Specify) <b>Burial</b>	23b. DATE <b>9-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Darr Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Ellington, Mo.</b>
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24. FUNERAL DIRECTOR <b>Pewitt Funeral Home, Ellington, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9/27/58</b>	26. REGISTRAR'S SIGNATURE <b>R. M. ...</b>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED

MAP 20 1959

OCT 3 1958

BUTLER CO. HEALTH CENTER

FILE-No. \_\_\_\_\_

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 *Chas. L. Smith*

Licensed Embalmer No. 4574

P. O. Address Ellington

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.