

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

58-037929
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 10269

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>St. Louis-Little</u> INSTITUTION <u>Rock Hosp., Inc.</u>		Length of stay in lb <u>10-days</u>	d. STREET ADDRESS (If outside, give location) <u>909 South Boyle</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Francis</u> Last <u>King Sr.</u>			4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1885</u>
9. AGE (In years last birthday) <u>73</u>		10. FUNDING YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensr. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>T.R.R.A. RR.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Bernard King</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>489-18-1885</u>	17. INFORMANT Address <u>Mrs. Nellie T. King, 909 So. Boyle Ave.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterioscleratic Heart Disease</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>October 17, 1958</u> , to <u>October 26, 1958</u> last saw him alive on <u>Oct 26 58</u> Death occurred at <u>11:15 p</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Am Bayard</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>1755 S. Grand Blvd.</u>	22c. DATE SIGNED <u>10, 27, 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 29, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>A. J. Donnelly Funeral Home</u> ADDRESS <u>St. Louis</u>		25. DATE RECD. BY LOCAL REG. <u>MO OCT 27 58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>

(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

5. 300
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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 *Francis Williams*

Licensed Embalmer No. *3565*
P. O. Address *3840 Linden*

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.