

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043790

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1228

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before death, give name of institution) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Galena</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>no street address</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA PEARL KING</u>			4. DATE OF DEATH Month Day Year <u>December 19, 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1885</u>
9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Stone Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Lazarun Hayne</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Wyacc</u>	14. NAME OF HUSBAND OR WIFE <u>Finis King (deceased)</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>500-40-7756</u>	17. INFORMANT Address <u>Bernice King, Galena, Missouri</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>Acute Lymphatic Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
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 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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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>Dec 18, 1958</u> to <u>Dec 19, 58</u> and last saw her <u>alive on Dec 19, 1958</u> Death occurred at <u>3:05 p m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>James T. Good M.D.</u>		22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>12-22-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 21, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cape Fair Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Cape Fair, Missouri</u>
24. FUNERAL DIRECTOR <u>Jewell E. Windle</u> B.W. ADDRESS <u>Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-24-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

All diseases in Part I must use only standard nomenclature in item 18. No symptoms will be listed. 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

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 *Bernard F. Wright*

Licensed Embalmer No. *4293*

P. O. Address *Springfield*

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.