

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008410  
STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 149

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Sturgeon</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Univ. Medical Center</b>		Length of stay in lb <b>19 days</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>King</b> Last <b>King</b>			4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1959</b>
--	--	--	---

5. SEX <b>Female</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>7-19-'82</b>	9. AGE (In years last birthday) <b>76</b>	10. UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>-</b> Min. <b>-</b>	11. UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
-------------------------	----------------------------------	---	-------------------------------------	--	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
--	--	---	--

13a. FATHER'S NAME <b>Charles G. King</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Alexander</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
--	---	--

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>Unknown</b>	17. INFORMANT <b>MRS. J.M. BARNES</b>	Address <b>Sturgeon, Mo.</b>
--	---	--	---------------------------------

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>PNEUMONIA, ASPIRATION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>CEREBRO-VASCULAR ACCIDENT</b>		<b>11 days</b>
	DUE TO (c) <b>CEREBRAL ARTERIOSCLEROSIS</b>		<b>33 1/2 YEARS?</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>FRACTURE, RIGHT HIP, INTERTROCHANTERIC</b>		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>PT. LOST HER BALANCE IN HER HOME + FELL</b>
--	--

20c. TIME OF INJURY <b>11:00 a.m. MARCH 2, 1959</b>	<b>ON RIGHT HIP</b>
--	---------------------

20d. INJURY OCCURRED WHILE AT <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>HOME</b>	20f. CITY, TOWN, OR LOCATION <b>STURGEON</b>	COUNTY <b>BOONE</b>	STATE <b>MISSOURI</b>
--	---	---	------------------------	--------------------------

21. I attended the deceased from <b>11 MARCH '59</b> to <b>30 MARCH '59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>30 MARCH '59</b> Death occurred at <b>11:29 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <b>John L. Holmer, M.D.</b>	(Degree or title)	22b. ADDRESS <b>Univ. of Missouri, Med Center, Columbia, Mo.</b>	22c. DATE SIGNED <b>30 MARCH '59</b>
---	-------------------	---	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>Apr. 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Sturgeons, Boone Co., Mo.</b>
--	----------------------------------	---	--

24. FUNERAL DIRECTOR <b>Elmer Meador, Sturgeon, Mo.</b>	ADDRESS <b>Marion</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 31 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R.E. Palmer</b>
--	--------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

APR 8 1959

MAY 1 1963

APR 1 1963

APR 8 1959

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 *Bill J. Meador* ..... Licensed Embalmer No. *4876* P. O. Address *Sturgeon, Missouri*

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.