

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008607
STATE FILE NUMBER

FILED MAR 31 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 92

800
-57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fulton</u> OR TOWN <u>Fulton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Williamsburg</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>Callaway Mem. Hosp.</u>		d. STREET ADDRESS <u>Williamsburg</u>	
Length of stay in lb <u>2da vs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Elton</u> Middle <u>King</u> Last <u>King</u>			4. DATE OF DEATH Month <u>March</u> Day <u>24th</u> Year <u>1959</u>		
---	--	--	---	--	--

5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1879</u>	9. AGE (In years last birthday) <u>80</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
--------------------------------	----------------------------------	--	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	11. BIRTHPLACE (City and state or country) <u>Guthrie, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	--	---

13a. FATHER'S NAME <u>Robert King</u>	13b. MOTHER'S MAIDEN NAME <u>Winnie Johnson</u>	14. NAME OF DECEASED OR WIFE <u>Rosa Belle King</u>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>489-09-9536</u>	17. INFORMANT <u>James King, Fulton, Missouri</u>	Address
---	---	--	---------

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>CEREBROVASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</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)		

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.) <u>331X</u>
---	---

20c. TIME OF INJURY Hour _____ 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 <u>Fulton</u>	COUNTY <u>Missouri</u>	STATE
---	--	--	---	---------------------------	-------

21. I attended the deceased from <u>3-23-59</u> to <u>3-24-59</u> and last saw <u>him</u> alive on <u>3-23-59</u> Death occurred at <u>9:45 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>James E. Hill MD</u>	22b. ADDRESS <u>Fulton, Mo</u>	22c. DATE SIGNED <u>3-24-59</u>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/28/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Southside Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fulton, Missouri</u>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Georgette Green, Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>March 28, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Maritta Lawrence</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Gayett Green*

Licensed Embalmer No. *4220*
P. O. Address *Attala, Mo*

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.