

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 5 1960

STATE FILE NUMBER

Registration District No. 176 Primary Registration District No. 3033 Registrar's No. 198

EMENDED

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in lb <u>77 yrs</u>	c. CITY OR TOWN <u>Lebanon</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>Wallace Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>387 Clough</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Mary</u> Last <u>King</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>F</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>5/5/1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____
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>-</u>	11. BIRTHPLACE (City and state or country) <u>Lebanon, Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>Fred King</u>		13b. MOTHER'S MAIDEN NAME <u>Amelia West</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Marion 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>none</u>		17. INFORMANT <u>Dwight King Lebanon Mo.</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8-10 yrs</u>
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident (hemorrhage)</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive vascular disease</u>		
DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					

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>12/10/59</u> to <u>12/23/59</u> and last saw her alive on <u>12/23/59</u> Death occurred at <u>11:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>R. W. Froelich, M.D.</u> (Physician or other)	22b. ADDRESS <u>Lebanon Mo</u>	22c. DATE SIGNED <u>12/26/59</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/28/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) <u>Lebanon Mo.</u>
24. FUNERAL DIRECTOR <u>Dorsey M. Howe Lebanon, Mo.</u> ADDRESS _____		25. DATE RECD BY LOCAL REG. <u>12-28-1959</u>	26. REGISTRAR'S SIGNATURE <u>Blilla S. Hays</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Harvey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 7

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.