

Registration District No. 395

Primary Registration District No. 5551A

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
PTD #1, Blue Springs, Mo  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 7  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME KM C. KING 520

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Margaret King 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Oct 14 - 1879  
(Month) (Day) (Year)

8. AGE: Years 1 Months 5 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jackson Co. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Phillips Oil Co

12. Name Stephen

13. Birthplace England  
(City, town, or county) (State or foreign country)

14. Maiden name Malissa Hooper

15. Birthplace England  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Margaret King

(b) Address Blue Springs Mo

17. (a) Rural (b) Date thereof 3-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mo

18. (a) Signature of funeral director J. O. Webb

(b) Address Oak Grove Mo

19. (a) April 11, 1940 (b) Mrs. Thomas Cortwood  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. PTD #1, Blue Springs, Mo  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24th  
year 1940 hour 1:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from March 24th, 1940 to March 24, 1940 that I last saw him alive on March 24, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 20 min

Due to Vascular degeneration - arterial

Due to arterial 5 yrs

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W J Rowe (M. D. number)  
Address Blue Springs, Mo Date signed 3-25-40

Duration  
20 min  
5 yrs  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed 

Licensed Embalmer No. 2353

P. O. Address Blue Springs 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12250

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 395

Primary Registration District No. 5321A

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town On a farm  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm C. King

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife 1872  
7. Birth date of deceased Oct 4 1872 (Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 20 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) April 11, 1940 (Date received local registrar) (b) Mrs. Thomas Portwood (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

GENERAL CERTIFICATION

20. DATE OF DEATH Month Mar day 24 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. G. Rowe (M. D. or other) Address Blue Springs

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940  
S-11250