

FILED NOV 3 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35048

State File No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------------|--|---|----------------------|----------------------------|--|---|--|---|--|--|--|---|--|--|--|--|--|---|--|--|--|------------------------------------|--|--|--|
| BIRTH NO. <u>124</u> | | REG. DIST. NO. <u>316</u> | | PRIMARY REG. DIST. NO. <u>3059</u> | | Registrar's No. <u>322</u> | | | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Bonne Terre</u> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bonne Terre Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Fort Leonard Wood</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> STREET ADDRESS (If rural, give location) <u>in Dent County Mo</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Alma</u> b. (Middle) <u>Marie</u> c. (Last) <u>King</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 23 1954</u> | | 5. SEX <u>female</u> | | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | | 8. DATE OF BIRTH <u>Dec 28 1890</u> | | 9. AGE (In years last birthday) <u>63</u> | | IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u> | | IF UNDER 2 HRS. Hour <u></u> Min. <u></u> | | | | | | | | | |
| 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 | | | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Farmington Missouri</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | | | | | | | | | |
| 13a. FATHER'S NAME <u>John Brockmiller</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Emma Clave</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>O. D. 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>488-16-9658</u> | | | | 17. INFORMANT'S SIGNATURE OR NAME <u>O. D. King</u> | | | | ADDRESS <u>Farmington Missouri</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive cardiovascular disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | | | | | | | | | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial pneumonia</u> | | | | 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION <u>443X</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21f. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>10/19</u> , 19 <u>54</u> , to <u>10/23</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10/23</u> , 19 <u>54</u> , and that death occurred at <u>1:00P</u> m., from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Jack W. Fuller M.D.</u> | | | | | | | | 23b. ADDRESS <u>Bonne Terre, Missouri</u> | | | | 23c. DATE SIGNED <u>10/25/54</u> | | | | | | | | | | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 24b. DATE <u>Oct 26 1954</u> | | | | 24c. NAME OF CEMETERY OR CREMATORY <u>Copenhagen</u> | | | | 24d. LOCATION (City, town, or county) (State) <u>Farmington Mo</u> | | | | | | | | | | | | | | | |
| DATE REC'D BY LOCAL REG. <u>Oct 26 1954</u> | | | | REGISTRAR'S SIGNATURE <u>Ether Rudloff</u> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>G. H. Cozear</u> | | | | ADDRESS <u>Farmington Mo</u> | | | | | | | | | | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 9 1958

NOV 2 1958

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..... *CH Cozear*
Licensed Embalmer No. *408*
P. O. Address *Farlington?*

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.