

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36529

FILED NOV 28 1950

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 118

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOONVILLE Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL SAGINE TWP 0370	
d. FULL NAME OF HOSPITAL OR INSTITUTION BOONSLICK BOARDING HOME		d. STREET ADDRESS (If rural, give location) NEAR WOODRIDGE Mo	

3. NAME OF DECEASED (Type or Print) GEORGE	a. (First) W	b. (Middle)	c. (Last) KINGEY	4. DATE OF DEATH (Month) (Day) (Year) Nov. 22. 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH AUG 23-1874	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months	11. UNDER 1 HRS. Days	12. CITIZEN OF WHAT COUNTRY? U. S
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER	10b. KIND OF BUSINESS OR INDUSTRY CROP FARMING	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S
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13a. FATHER'S NAME ANDREW KINGEY	13b. MOTHER'S MAIDEN NAME ELIZABETH GANN	14. NAME OF HUSBAND OR WIFE SINGLE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME L. F. Rauffman Jeff. City Mo	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerosis		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 4500
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **April 1947**, to **Nov 22, 1950**, that I last saw the deceased alive on **11/19, 1950**, and that death occurred at **1:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE M. L. Dickraegen M.D. (Degree or title)	23b. ADDRESS Boonville Mo.	23c. DATE SIGNED 11/24/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Nov 23, 1950	24c. NAME OF CEMETERY OR CREMATORY COPPS CHAPEL CEM	24d. LOCATION (City, town, or county) (State) NEAR WOODRIDGE Mo
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DATE REC'D BY LOCAL REG. 11-23-50	REGISTRAR'S SIGNATURE D. Cooper	381	25. FUNERAL DIRECTOR'S SIGNATURE G. Albert Hornbeck	ADDRESS Boonville Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED ¹¹⁻²⁷⁻⁵⁰
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Filed ¹¹⁻²⁷⁻⁵⁰ _____

W.C. 131850

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
Student Embalmer

Signed C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Praine Home Inc.

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, fact should be so stated above.