

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Andrew Co  
Township Adams  
or  
Village Savannah  
or  
City (NO. .... St. .... Ward)

Registration District No. 13  
Primary Registration District No. H.P.D.

File No. 31333  
Registered No. H.C.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Nelson Sears McKnight

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH February 20<sup>th</sup> 1888  
(Month) (Day) (Year)

7 AGE 88 yrs. 8 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farming  
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Livingston Co., N.Y.

PARENTS  
10 NAME OF FATHER Thomas McKnight  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) New York  
12 MAIDEN NAME OF MOTHER Maguel Bates  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Fred H. Simons  
(Address) Savannah Mission

15 Filed Oct 30 1914 W. H. W. M.D.  
Registrar

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Oct 29  
(Month) (Day) (Year) 1914

17 I HEREBY CERTIFY, that I attended deceased from Oct 20, 1914, to Oct 29, 1914, that I last saw him alive on Oct 29, 1914, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH\* was as follows:

dysentery  
epidemic  
12 B  
14  
(Duration) 14 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)  
(Duration) 0 yrs. 0 mos. 0 ds.  
(Signed) M. Martin M. D.  
Oct 30, 1914 (Address) Savannah

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Savannah DATE OF BURIAL Oct 30, 1914  
20 UNDERTAKER Charley Mitchell Savannah  
ADDRESS

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

No. 1. 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.

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County Audrew Registration District No. 13 File No. \_\_\_\_\_

Township Savannah or Village Savannah or City \_\_\_\_\_ (MO) \_\_\_\_\_ (St.) \_\_\_\_\_ (Ward)

Primary Registration District No. 4010 Registered No. 13

FULL NAME Nelson Sears Mc Knight [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE  MARRIED Married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

PARENTS

NAME OF FATHER	_____
BIRTHPLACE OF FATHER (City or town, State or foreign country)	_____
MAIDEN NAME OF MOTHER	_____
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	_____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Mc Knight

(ADDRESS) Savannah Mo

Filed X 60 30 1914 Wm. Kern REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 29, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191\_\_\_\_, to \_\_\_\_\_ 191\_\_\_\_, that I last saw him \_\_\_\_\_ 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ M. D.

\_\_\_\_\_ 191\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former, or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SATISFACTORY INFORMATION SUPPLIED  
 SUPPLEMENTARY CERTIFICATE  
 SATISFACTORY INFORMATION SUPPLIED

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