LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

25747

1. PLACE OF DEATH
County: Cedar — Registration District No.: 163 — File No.:
Township: Box — Primary Registration District No.: 5228 — Registered No.: 54
City: (No. ..... St. ..... Ward)

2. FULL NAME: Anna C Goodknight
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: James Goodknight

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 16 1889

7. AGE: Years 35 — Months 1 — Days 21 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At House 23A 11A
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Neb

PARENTS
10. NAME OF FATHER: H. P. Nelson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Denmark
12. MAIDEN NAME OF MOTHER: Anna Olson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Denmark

14. INFORMANT: Anna Talbott
(Address): El Dorado Spgs. Mo

15. FILED: 9, 9, 1924 W. O. Danson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 7 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1924, to Sept 7, 1924, that I last saw her alive on Sept 7, 1924, and that death occurred, on the date stated above, at 1 0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
Unknown 11A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Influenza
Unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. P. Joyston, M. D
Sept 8, 1924 (Address) El Dorado Spring

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hazel Dell — DATE OF BURIAL: 9/8 1924

20. UNDERTAKER: M D Gurman, El Dorado Spgs. Mo — 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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | 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.