~~LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT~~

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

15406

1. PLACE OF DEATH

County: Jasper — Registration District No.: 417 — File No.:

Township: — Primary Registration District No.: 3021 — Registered No.: 71

City: Webb City, Jasper County Tuberculosis Hospital — St. — Ward)

2. FULL NAME Lillie Opal Knight

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

Length of residence in city or town where death occurred: yrs. mos. 2 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)
Female	white	married

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Bert Knight

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 19, 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	8	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): House Keeping

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Greene County, Mo.

PARENTS

10. NAME OF FATHER Jefferson Conway

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

12. MAIDEN NAME OF MOTHER Fannie Brooks

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

14. INFORMANT Mrs. Fannie Conway
(Address) La Russell, Mo.

15. FILED 5/3, 1925 R. M. Sermont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3" 1925

17. I HEREBY CERTIFY, That I attended deceased from May 1" 1925, to May 3" 1925, that I last saw her alive on May 3" 1925, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis, pulmonary, chronic

22A 31

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination

(Signed) Harvey Hazlewood, M. D
May 4, 1925. (Address) Jasper County Tuberculosis Hospital Webb City, Missouri

*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
Harvey Cemetery	5/4 1925

20. UNDERTAKER	ADDRESS
Sarcoxie Med Co	Sarcoxie Mo

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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