

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

Do not use this space.

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1. PLACE OF DEATH
 County Boone Registration District No. 73
 Township Columbia Primary Registration District No. 3006
 City (No. _____) St. _____ Ward _____
 2. FULL NAME Mary Laura Knight
 (a) Residence No. 217 Waugh 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John H Knight
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-25-1845
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 4 17
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12 - 1930
 17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930 to Jan 24, 1930
 that I last saw her alive on Jan 12, 1930 and that death occurred, on the date stated above, at 9:05 m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
 (duration) yrs. mos. ds. 3
 CONTRIBUTORY Senility
 (SECONDARY) (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Callaway Co. Missouri
 (STATE OR COUNTRY)
 10. NAME OF FATHER James Cleggman
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Mary Morgan
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Virginia
 (STATE OR COUNTRY)

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) Ross Spauld, M. D.
1/13, 1930 (Address) Columbia Mo.

14. INFORMANT W.C. Knight
 (Address) Columbia Mo
 15. FILED 1/13, 1930 Beatrice Gubb
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Columbia Mo. Cem DATE OF BURIAL 1-14-1930
 20. UNDERTAKER W.T. Wandewerter ADDRESS Columbia Mo.

N. B.—Every item on this certificate is important. AGE should be stated properly classified. Exact statement of cause of death in terms of disease, if known, should be given.

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B--Dover team

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Boone Registration District No. 73 File No.
 Township Columbia Primary Registration District No. 22.6 Registered No.
 City (No.) St. Ward

2. FULL NAME Mary Laura Knight
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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)

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 Mar 24 30 Beatrice Guebbel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1930

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:
Pneumonia Bronch

CONTRIBUTORY (SECONDARY) 100% (duration) 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.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact status of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR SPECIFICATIONS UNTIL THEY ARE. BY LAW

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