

JUN 25 1930

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

✓ 15767

1. PLACE OF DEATH

 County Hunklin
 Township Union
 City (No. _____) _____

 Registration District No. 282
 Primary Registration District No. 5401

 File No. _____
 Registered No. 18
 St. _____ Ward _____

2. FULL NAME

Louisa L. Knox

 (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)

widow

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

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

Dec 20 - 1856

7. AGE

YEARS

MONTHS

DAYS

 If LESS than 1
 day, _____ hrs.
 or _____ min.

73
4
24

8. OCCUPATION OF DECEASED

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

Home Keeping

(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)

Mo.

10. NAME OF FATHER

R M Hattery

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

N. Carolina

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14. INFORMANT

(Address)

Hue Knox
Campbell Mo.

15. FILED

5/5, 1930
Edw. Anderson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

17.

 I HEREBY CERTIFY, That I attended deceased from 2/2, 1929, to 2/14, 1930
 that I last saw her alive on 2/14, 1930, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
27 A 1
11 P
(duration) yrs. 18 mos. ds.

CONTRIBUTORY (SECONDARY)

Influenza
(duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physical(Signed) J. McQuide, M. D., 19 _____ (Address) Piggott, Ark

*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

Gravel Hill Ark.

19 _____

20. UNDERTAKER

ADDRESS

Edw Anderson Campbell

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH.
 County Dunklin Registration District No. 282 File No. _____
 Township Union Primary Registration District No. 5401 Registered No. 18
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Louisa L. Knox
 (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.
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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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Pulmonary X

CONTRIBUTORY (SECONDARY) Influenza
 (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.

14. INFORMANT _____ (Address) _____

15. FILED 5/15 1930 E. W. Bauder REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____	DATE OF BURIAL _____
20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

S-15767