

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

Do not use this space.

21367

1. PLACE OF DEATH

Count *Democrat*  
Township *Butler*  
City *Portageville* (No. .... St. .... Ward)

Registration District No. *114*  
Primary Registration District No. *5917*

File No. *10*  
Registered No. .... St. .... Ward)

2. FULL NAME

*Donald F. Knight*  
(a) Residence, No. *Portageville* St. .... Ward. (If nonresident, give city or town and State)  
(Usual place of abode) *Portageville*  
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 <i>Female</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Infant</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>7-14-34</i>				
7. AGE	YEARS <i>2</i>	MONTHS <i>11</i>	DAY <i>5</i>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. <i>Infant</i>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Infant</i>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-19-34*

22. I HEREBY CERTIFY, That I attended deceased from *last patient only once & on June 16, 1934*  
19... to...  
I last saw h. or alive on *June 16, 1934*. Death is said to have occurred on the date stated above, at *7 a.m.*  
The principal cause of death and related causes of importance were as follows:  
*Enterocolitis*

Other contributory causes of importance:  
*None*

Name of operation *None* Date of...  
What test confirmed diagnosis? ... Was there an autopsy? *No*

Date of onset  
*June 12 34*

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Portageville Mo</i>
	13. NAME <i>Donald F Knight</i>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Morganfield Mo</i>
	15. MAIDEN NAME <i>Mary Workman</i>
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Portageville Mo</i>
	17. INFORMANT (ADDRESS) <i>D F Knight Portageville Mo</i>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Portageville 6-19-34</i>
	19. UNDERTAKER (ADDRESS) <i>R M Payne Portageville Mo</i>
20. FILED	19... Registrar.

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ... Date of injury... 19...  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury *X*  
Nature of injury *X*

24. Was disease or injury in any way related to occupation of deceased? *No*  
If so, specify...  
(Signed) *J A Reeser*, M. D.  
(Address) *Portageville, Mo.*

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.

JUL 30 1934

... should be stated EXACTLY. EXACT STATEMENT OF OCCUPATION is very important.

... FOR THE ...

...

...

**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 Boonville  
Township Butler  
City Boonville (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

Registration District No. 114  
Primary Registration District No. 5867

File No. \_\_\_\_\_  
Registered No. 10

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-14-31

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>2</u>	<u>11</u>	<u>5</u>		

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Widow

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 7/10 19 34 Ch. Cook Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 19, 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Gastro Colitis

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_

(Signed) A. A. Reader, M. D.  
(Address) Boonville mo

SUPPLEMENTARY

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

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