

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

Do not use this space.

JUN 6 1936

21333

1. PLACE OF DEATH

791

County.....

Registration District No.....

Township.....

City Registration District No.....

City.....

(No.....)

City Registration District No.....

St.....

Ward.....

2. FULL NAME

(a) Residence, No.....

(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

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 20th 1920*

7. AGE YEARS *16* MONTHS *3* DAYS *19* IF LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 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) *Ill. Tenn.*

13. NAME *Clara Mc Knight*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

15. MAIDEN NAME *Myrtle Anderson*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

17. INFORMANT (ADDRESS) *Julia Anderson*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery 29 36*

19. UNDERTAKER (ADDRESS) *Ryan & Co*

20. **MAY 28 1936** *J. F. Brudick* Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 9th 1936*

22. I HEREBY CERTIFY, That I attended deceased from *5-8-36*, to *5-9-36*, 1936.

I last saw her alive on *5-9-36*, 1936. Death is said to have occurred on the date stated above, at *7:30 P.*

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

Miliary Tuberculosis
Other contributory causes of importance: *32a*

Date of onset *5-8-36*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? *Yes*

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) *J. B. Harris*, M. D.

(Address) *2948*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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