

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.

MAY 18 1937

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No. 15752
 Township Franklin Primary Registration District No. 100 Registered No. 457
 City Waverly (No. Mo. Meth. Hosp.) St. _____ Ward _____
 2. FULL NAME Carolyn Irene Knorr P. R. # Mo.
 (a) Residence, No. Mo. Meth. Hosp. St. _____ Ward _____ Maysville 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Stillborn</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>4-13-37</u>		
7. AGE	YEARS <u>0</u>	MONTHS <u>0</u>
	DAYS <u>0</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	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) <u>Springfield Mo.</u>		
FATHER	13. NAME <u>Cross Knorr</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dudack Co. Mo.</u>	
MOTHER	15. MAIDEN NAME <u>Eva Irene Dill</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Clinton Co. Mo.</u>	
17. INFORMANT <u>Carol Knorr</u> (ADDRESS) <u>Maysville Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Waverly Chapel</u> DATE <u>4/14/37</u>		
19. UNDERTAKER <u>W. G. Clepper</u> (ADDRESS) <u>Maysville Mo.</u>		
20. FILED <u>4-14-37</u> 19 <u>37</u> <u>H. B. Keasley</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/13 1937

22. I HEREBY CERTIFY, That I attended deceased from 4-13 1937, to 4-13 1937.
 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:
Stillborn Long labor
 Date of onset 4-13-37

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? ✓ Was there an autopsy? No.

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? No
 If so, specify _____
 (Signed) H. B. Keasley, M. D.
 (Address) St. Joseph Mo.

