

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 13 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28541

State File No.

Registrar's No.

Registration District No. 72

Primary Registration District No. 4041

52

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Centralia Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 20 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Centralia
(If outside city or town limits, write "RURAL")
(d) Street No. me
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME

John Leachman Knight

8. (b) If veteran, name war Civil War

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased April 7 1837
(Month) (Day) (Year)

8. AGE: Years 102 Months 4 Days 7
If less than one day hr. min.

9. Birthplace Tex
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

MOTHER FATHER { 12. Name John Leachman Knight Sr.

13. Birthplace Tex
(City, town, or county) (State or foreign country)

14. Maiden name Callaway Co Mo
(City, town, or county) (State or foreign country)

15. Birthplace Callaway Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Foster
(b) Address Centralia Mo

17. (a) Burial (b) Date thereof Aug 16 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Cedar Church

18. (a) Signature of funeral director M. M. Bond
(b) Address Centralia Mo
19. (a) 8/16/1939 (b) F. H. Bond M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14th
year 1939 hour 10 minutes 50 M.
21. I hereby certify that I attended the deceased from 6/30
1939, to 8/14/39 1939;
that I last saw him alive on 8/14/39 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Due to Senility
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(e) Means of injury
23. Signature [Signature] (M. D. or other)
Address Centralia Mo Date signed 8/16/39

1116

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28541
Do not use this space.

1. PLACE OF DEATH
 (a) County Boone Registration District No. 72
 (b) Township Centralia Primary Registration District No. 4041 Registered No. 52
 (c) City..... (d) Street No..... St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME John Leechman Wright
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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. ormin. |
|--------|------------|----------|----------|--|
| | <u>102</u> | <u>4</u> | <u>7</u> | |
- OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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 _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
- MOTHER
15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED _____ 19 _____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 14 1939
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:
Hypostatic pneumonia
Secondary
Bronchial
 Date of onset _____
- Other contributory causes of importance: 107k
- 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) G. M. Furness M. D.
 (Address) Centralia mo

SUPPLEMENTAL

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 COMPLETED AS PRESCRIBED BY LAWS.

