

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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1939 OCT 20

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

32566
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson - 3 Registration District No. 398
 (b) Township Jackson Primary Registration District No. 3019 Registered No. 283
 (c) City Independence (d) Street No. 522 W. Walnut 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Mrs Mary Knox

(a) Residence, No. 3206 Summit K.C. Mo. 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. Andrew C. Knox
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 6 - 1874
 7. AGE YEARS 65 MONTHS 7 DAYS 1 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
 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) Independence Missouri
 FATHER 13. NAME William L. Mc Coy
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
 MOTHER 15. MAIDEN NAME Fannie Sawyer
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
 17. INFORMANT (ADDRESS) Dr. Andrew C. Knox 3206 Summit St.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn DATE Sept 9 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Off + Mitchell Independence, Mo.
 20. FILED 9-8 1939 F. L. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7 1939
 22. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1939, to _____, 19____.
 I last saw him alive on Sept 7, 1939. Death is said to have occurred on the date stated above, at 7:50 m.
 The principal cause of death and related causes of importance were as follows:
Acute Cardiac Dilatation (myocardial)
seen this pt. one hour before death
 Date of onset _____
 Other contributory causes of importance: Cholera, Malaria, Mastoiditis
 Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical 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) George Trueman, M. D.
 (Address) Independence
Mo.

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.