

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

32651
Do not use this space.

1. PLACE OF DEATH *10-19-39*
 (a) County *Jasper* Registration District No. *44*
 (b) Township *Jasper* Primary Registration District No. *2003* Registered No. *St. James Hospital*
 (c) City *Jasper* (d) Street No. *St. James Hospital* St. *St. James Hospital*
 (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 *Core Knight*
 (a) Residence, No. *124 Main St.* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widow*
 5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *Conson T. Knight*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *unknown*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *about 70 ? ?*
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Prop*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Rooming house*
 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) *Sep 30, 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *Sept 26, 1939, to Sept 30, 1939*
 I last saw him alive on *9-30-39* Death is said to have occurred on the date stated above, at *St. James Hospital*.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
 Date of onset *8-24*
 Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No record*
 13. NAME *Hot Martin*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *no record*
 15. MAIDEN NAME *Rachael*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *no record*
 17. INFORMANT (ADDRESS) *Mrs Crystal Williams Kansas City Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *Castroville Mo 9-3-39*
 19. FUNERAL DIRECTOR (ADDRESS) *St. James Hospital*
 20. FILED *10-2-39* *Ed Jones* Local Registrar

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
 Was disease or injury in any way related to occupation of deceased?
 (Signed) *E. J. Henney* M. D.
 (Address) *311 Sumner Bldg*

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.

St. James Hospital

RECEIVED

District Health Officer No. 6,

District File Number 1039-2066

Date Filed OCT. 14 1939

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L: E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed Steve D. Parker

Licensed Embalmer No. 2048

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.)