

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 13

Primary Registration District No. 5017

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rural Jefferson Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
One and One half miles South Savannah
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 60 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1 1/2 mi South Savannah
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Lillian Mc Knight 258
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 29th
year 1939 hour 12:40 AM minute _____ M.
21. I hereby certify that I attended the deceased from Nov 2
_____, 1939, to Nov 29, 1939;
that I last saw her alive on Nov 28, 1939;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death Chronic Endocarditis
Duration _____

7. Birth date of deceased October 28 1861
(Month) (Day) (Year)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 78 Months I Days I If less than one day _____ hr. _____ min.
9. Birthplace Quitman Mo.
(City, town, or county) (State or foreign country)

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

10. Usual occupation None Blind
11. Industry or business _____
12. Name Nelson Mc Knight
13. Birthplace Un known Wisconsin
(City, town, or county) (State or foreign country)
14. Maiden name Betsy Morgan
15. Birthplace Un known New York
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Mc Knight
(b) Address Savannah Mo.

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? _____

17. (a) Burial (b) Date thereof Nov 30 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Savannah Mo.

While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director C. C. Breit
(b) Address Savannah Mo.
19. (a) Nov 30 39 (b) Mrs. Jennie Rash
(Date received local registrar) (Registrar's signature)

23. Signature Dr. R. Wilson (M. D. or other) _____
Address Acendale mo Date signed Nov 29 1939

WHILE IN LIVING - 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.

Embalmer No. 193

State File No. 1239-1714

Date Filed 12-15 1939

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

E. C. Breit, Registered Apprentice No. _____

working under my personal supervision.

Signed E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah mo

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.