

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40129

State File No. _____

Registration District No. 477

Primary Registration District No. 4286

Registrar's No. 46

1. PLACE OF DEATH:
(a) County Lewis
(b) City or town Canton
(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.
In this community _____ years, months or days

3. (a) PRINT FULL NAME Lucinda Rounsavell Knight
523
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Adelbert Knight 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 25, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 4 5 hr. _____ min.

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

10. Usual occupation Retired housewife

11. Industry or business _____
12. Name Cyrus Stout Rounsavell
13. Birthplace Adams Co. Ohio
14. Maiden name Sarah Ellen Short
15. Birthplace Scotland Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Paul Knight
(b) Address Missouri - Du Moulin, La
17. (a) Burial (b) Date thereof Nov. 1, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Benjamin, Mo.

18. (a) Signature of funeral director Earl H. Porter
(b) Address Canton, Mo. 4286
19. (a) Nov. 2, 1939 (b) H. W. Harris M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lewis
(c) City or town Canton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30th
year 1939 hour 11 minute 30 A.M.
21. I hereby certify that I attended the deceased from 10-27-39
_____, 19____, to 10-30, 19____;
that I last saw her alive on 10-30, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute pericarditis
Duration 4 days
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none
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 Dr. Earl Porter (M. D. or other D.O.)
Address Canton, Mo. Date signed 11-2-39

RECEIVED

District Health Officer No. 10

District File Number 12-39-2087

Date Filed DEC 7 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.....

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

Signed

Carl H. Barkley

Licensed Embalmer No. 2615

P. O. Address Canton, 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.