JAN 16 1940

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

43801
Do not use this space.

1. PLACE OF DEATH
(a) County LACLEDE Registration District No. 449
(b) Township Primary Registration District No. 4267 Registered No.
(c) City LEBANON (d) Street No. 326 SOUTH JEFFERSON 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 25 VIRGINIA F. McKNIGHT
(a) Residence, No. 326 SOUTH JEFFERSON St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
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 J McKNIGHT
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT. 9 1853
7. AGE YEARS 86 MONTHS 3 DAYS 3 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) BELLE VUE MICH

FATHER
13. NAME RUBEN FITZGERALD
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MARYLAND

MOTHER
15. MAIDEN NAME FLORINDA ELDRED
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NY

17. INFORMANT (ADDRESS) [illegible] CE CLARK
18. BURIAL, CREMATION, OR REMOVAL PLACE LEBANON MO DATE DEC 13 1939
19. FUNERAL DIRECTOR (ADDRESS) PALMER'S LEBANON MO
20. FILED 12-15 1939 J A McComb Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) DEC 11th 1939
22. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1939, to Dec. 11th, 1939
I last saw h. W alive on Dec. 11th, 1939. Death is said to have occurred on the date stated above, at 2:45 A m.
The principal cause of death and related causes of importance were as follows:

Pneumonia (Hypo-static)

Date of onset

Other contributory causes of importance: myocarditis + fractured hip

Name of operation none Date of
What test confirmed diagnosis? Physical 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? no
If so, specify
(Signed) J. L. Benage, M. D.
(Address) Lebanon Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

144 to 97

RECEIVED
District Health Officer No. 7,
District File Number 1-40-125
Date Filed 1-10-40

STATEMENT BY LICENSED EMBALMER

I, D A Palmer, Licensed Embalmer No. 1161

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

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed D A Palmer

Licensed Embalmer No. 1161

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.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

43801
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1. PLACE OF DEATH
(a) County Laclede — Registration District No. 449
(b) Township — Primary Registration District No. 4267 — Registered No.
(c) City Lebanon — (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 Virginia F McKnight
(a) Residence, No. ..... St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
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 86 — MONTHS 3 — DAYS 3 — If LESS than 1 day, ... hrs. or ..... min.

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) Dec 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..., 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:

	Date of onset
Pneumonia Hypostatic	

Other contributory causes of importance:
Myo Carditis + Fractured Hip

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 3/17, 1939
Where did injury occur? Lebanon, Laclede Co. Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
In home
Manner of injury Fall
Nature of injury Fractured hip

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) J. L. Benage, M. D.
(Address) Lebanon Mo

SUPPLEMENTARY

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 CO[illegible] RESCRIBED BY LAW.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No.....

(c) City..... (d) Street No.....

(If death occurred in Hospital or Institution, write its name instead

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth

2. PRINT FULL NAME.....

(a) Residence, No..... St. ☐

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper.

9. Industry or business in which was done, as saw mill, b

10. Date deceased last w this occupation (year) .....

12. BIRTHPLACE (STATE C

REFER

21. D

CAUSE OF

so that it may be properly classified. Exact statement of OCCUPATION is very important.