

Registration District No. 657

Primary Registration District No. 4388

Registrar's No. 133

1. PLACE OF DEATH:
(a) County Prineas
(b) City or town Carruthersville
(c) Name of hospital or institution: W. 7th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

8. (a) PRINT FULL NAME MARTHA JANE KNOTT
8. (b) If veteran, name war X 8. (c) Social Security No. X

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 _____ years

7. Birth date of deceased Sept. 23, 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 3 0 hr. min.

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

10. Usual occupation none

11. Industry or business none

12. Name Bate Knott
13. Birthplace Carruthersville, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Martha M. McLean
15. Birthplace Carruthersville, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nellie McLean
(b) Address Carruthersville, Mo.

17. (a) Burial (b) Date thereof 12/23/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carruthersville, Mo.

18. (a) Signature of funeral director L. J. Fargis
(b) Address Carruthersville, Mo.
19. (a) Dec. 30, 1939 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Prineas
(c) City or town Carruthersville
(If outside city or town limits, write "RURAL")
(d) Street No. W. 7th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22nd
year 1939 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov 5
1937 to Dec 22 1939
that I last saw her alive on Dec 21 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral

Due to Rupture of shell above in chest wall.

Due to _____

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____

Of autopsy None

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 W. C. Castle (M. D. or other) _____
Address Carruthersville, Mo. Date signed 12/29/39

Duration 3 days

One week

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

RECEIVED

District Health Officer No. 3,

District File Number 140-815

Date Filed 1/19/40

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.....

Not Embalmed

....., 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.