

REG. DIST. NO. 23 1940

Primary Registration District No. 500-310

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Jackson Prairie
(b) City or town Jackson Home
(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 2
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME J. J. Knowles 542

3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex male 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

7. Birth date of deceased 5 (Month) 5 (Day) 1850 (Year)

8. AGE: Years 88 Months 10 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Iowa (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Farmer

11. Industry or business unknown

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
14. Maiden name unknown
15. Birthplace unknown

16. (a) Informant Ernest Jackson

(b) Address J. J. Home

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Mar 25 - 40 (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville Col of St

18. (a) Signature of funeral director Ketter Lind

(b) Address 116 2nd

19. (a) 3/30/40 (Date received local registrar) (b) Anna G. Seneb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town J. J. Home (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 Mar day 13 year 1940 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1, 1940 to 3-13, 1940
and that I last saw him alive on 3-12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senile debility

Due to: _____

Due to: 1621

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

(e) Specify type of place _____ (f) Means of injury _____

23. Signature J. W. Green (M. D. or other) _____

Address Depue Mo Date signed 3/18-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

40

11-1-18

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 William J. Hadd

Licensed Embalmer No. 3991

P. O. Address 5725 Virginia

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11221

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 400

Primary Registration District No. 5533

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Prairie
(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 (Specify whether)
In this community years, months or days

3. (a) PRINT FULL NAME J. Knowles

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive 5- years

7. Birth date of deceased 5 (Month) 18 (Day) 185 (Year)

8. AGE: Years 88 Months 10 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) 5/13/40 (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (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.

20. DATE OF DEATH Month May day 13 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

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 J. W. Green (M. D. or other) Address Independence signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL CERTIFICATE

1940

S-11221