

No. 2
11-10-39
7-39
K21

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14786

State File No. 4166

MAY 15 1940

Registration District No. 282

Primary Registration District No. 4166

Registrar's No. 7

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

1. PLACE OF DEATH: Dunklin

(a) County Dunklin

(b) City or town Campbell Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Home
(Specify whether

In this community Home most of life
years, months or days)

3. (a) PRINT FULL NAME Sarah Jane Knotts 532

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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June - 1 - 1847
(Month) (Day) (Year)

8. AGE: Years 92 Months 10 Days - If less than one day hr. _____ min. _____

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

10. Usual occupation Home wife

11. Industry or business _____

12. Name H. J. Watkins

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

14. Maiden name H. J.

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

16. (a) Informant Frank Hurdand

(b) Address Campbell Mo.

17. (a) Burial (b) Date thereof April - 3 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Hill

18. (a) Signature of funeral director Tandus & Son

(b) Address Campbell Mo.

19. (a) April - 3 - 40 (b) B. J. Watkins 256
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin

(c) City or town Campbell, Mo.
(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 April day 1
year 1940 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw her alive on March 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 John I. Brown (M. D. or other) I

Address Campbell Date signed 5-2-40

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RECEIVED

District Health Officer No. 2

District File Number 540-104

Date Filed 5/14/40

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.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14786

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 282

Primary Registration District No. 4166

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Campbell
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Sarah Jane Knotts

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

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

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

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 92 Months 10 Days _____ 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) _____ (b) Date thereof. (Month) _____ (Day) _____ (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1 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 Cancer
Small sore on right temple
Due to _____
glasses possibly

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

Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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)
(a) Means of injury _____

23. Signature John L. Brown (M. D. or other) _____
Address Campbell Mo Date signed _____

SUPPLEMENTAL COPY
8, 1940

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

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S-14786