

NOV 13 1940
Registration District No. **4216**

Primary Registration District No. **4248**

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.

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Sarcoxie
(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) 7
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 40 Years
years, months or days)

3. (a) PRINT FULL NAME Mary Ann Knight
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 Jess Knight **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased Oct. 22, 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 5 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
12. Name Robert Scott
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Hurt
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Ellen Evans
(b) Address 1106 Poplar St., Carthage, Mo.

17. (a) Burial _____ **(b) Date thereof** 4-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sarcoxie Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address 1208 Garrison, Carthage, Mo.

19. (a) April 7, 1940 **(b)** Mrs. Emma Brodaway
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Sarcoxie
(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 5th
year 1940 hour 3: minute 40 P.M.

21. I hereby certify that I attended the deceased from April 1, 1940, to April 6, 1940.
that I last saw him alive on April 6, 1940.
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 10 days

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? 40
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Sarcoxie, Mo. **Date signed** 4-7-40

10-5-84

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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.....

Edle...

Licensed Embalmer No.....

2222

P. O. Address.....

Ort...

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. 15779
Registrar's No. 5

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 416

Primary Registration District No. 4248

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Sarcoxia
(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 Mary Ann Knight

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..... year

7. Birth date of deceased Oct 22 1857
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 13 If less than one day..... hr..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) June 7 1949 (b) Mrs Leona Brown
(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.

20. DATE OF DEATH: Month apr day 5
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 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.....

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 P. B. York (M. D. or other).....
Address Sarcoxia Mo Date signed.....

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15779

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 416

Primary Registration District No. 4248

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Sarcoxie
(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, years, month or days)

3. (a) PRINT FULL NAME Mary Ann Knight

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

4. Sex 7 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	Months	Days	If less than one day
	<u>82</u>	<u>5</u>	<u>13</u>	_____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER } 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 5 year 1980 hour _____ minute _____ M.

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

Immediate cause of death Pneumonia

Tobacco

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 M.B. Jack (M. D. or other) _____
Address Sarcoxie Mo Date signed _____

SUPPLEMENTAL