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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22084

JUL 15 1940

Registration District No. 449 — Primary Registration District No. 4267 — Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

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

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

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether

In this community 55 years years, months or days)

522

3. (a) PRINT FULL NAME Sarah E Knight

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lawrence Knight

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

7. Birth date of deceased Feb (Month) 22 (Day) 1884 (Year)

8. AGE: Years 56 Months 3 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business 1

FATHER
12. Name Ed Davis
13. Birthplace Ind. (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Dorth Knox
15. Birthplace " " (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Viola McMenus

(b) Address Phillipsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/40 (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon Mo

19. (a) 5-31-40 (Date received local registrar) (b) J A McComb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede

(c) City or town Lebanon 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 5 day 31 year 1940 hour 8 minute 80 a. M.

21. I hereby certify that I attended the deceased from 4-10-, 1940, to 5-30, 1940, that I last saw her alive on 5-30, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cirrhosis of liver	4 mon.
Due to Picks Syndrome	
Due to Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death) Hepatitis	24
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? — (Specify type of place)

While at work? — (e) Means of injury —

23. Signature Wm. J. Waihoja (M. D. or other) Ex. 1

Address Lebanon Ind. Date signed 5-31-40

Wyahoja

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7-40-967
Date Filed 7-1-40

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 Myself, Registered Apprentice No. ....., working under my personal supervision.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.