

Registration District No. 799

Primary Registration District No. H 479

Registrar's No. 36

1. PLACE OF DEATH: 2

(a) County Saline

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

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X
(Specify whether years, months or days) 5 1/2

In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____

(c) City or town Slater
(If outside city or town limits, write "RURAL")

(d) Street No. A
(If rural, give location)

(e) If foreign born, how long in U. S. A. A years.

3. (a) PRINT FULL NAME George Washington Knowles

3. (b) If veteran, name war A

3. (c) Social Security No. 709 12 3136

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 year 1940 hour 7 minute 5 P. M.

4. Sex Male

5. Color or race Wh.

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 15 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 19 39 to July 13 1940; that I last saw him alive on July 10 1940; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>35</u>	<u>2</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death Carcinoma of prostate.

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

Due to _____

Due to 51

10. Usual occupation Fireman

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

11. Industry or business R.R. Locomotive

12. Name Don't Know

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underlines the cause to which death should be charged statistically.

16. (a) Informant Pat Goodson

(b) Address Slater Mo.

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? _____

17. (a) Burial (b) Date thereof 7 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director Hill Brothers

(b) Address Slater Mo.

19. (a) 7 15 (b) W. M. Tuttle
(Date received local registrar) (Registrar's signature)

23. Signature M. C. ... (M.D. or other)

Address Slater Mo. Date signed 7-10-40

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

7
8
1

RECEIVED
District Health Officer No. 8
District File Number 8-18-40
Date Filed

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 _____

Edgar Moore

Registered Apprentice No. *230*

working under my personal supervision.

Signed *Sarah M. Hill*

Licensed Embalmer No. *1292*

P. O. Address *Slater Mo*

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.