DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 28 1941

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 44023

Registration District No. 810 Primary Registration District No. 6062 Registrar's No. 62

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

**1. PLACE OF DEATH**

(a) County: Scotland

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

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

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: all his life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Mo (b) County: Scotland

(c) City or town: Downing R. F. D.
(If outside city or town limits, write "RURAL")

(d) Street No.: Rural - Miller
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME: Ambrose Sherman Knight

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Male

5. Color or race: Wh

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: 9 (Month) - 6 (Day) - 1864 (Year)

8. AGE: Years 76 Months 3 Days 17 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Jim Knight
13. Birthplace: Dent County (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Anna Simpkins
15. Birthplace: Dent County (City, town, or county) (State or foreign country)

16. (a) Informant: Fayrol Watson
(b) Address: Downing Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-26-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Friendship

18. (a) Signature of funeral director: C. E. Hopper
(b) Address: Memphis Mo

19. (a) Dec. 31-1940 (Date received local registrar) E. O. Farrish (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 24 year 1940 hour 9:00 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__; that I last saw him alive on Dec 24 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart failure — Duration
due to heavy drinking
and exposure from
Due to: laying out while
drunk (Verdict
Due to: of jury (coroner)

Other conditions (Include pregnancy within 3 months of death): No

Major findings:
Of operations: No

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? No
While at work? (Specify type of place) (e) Means of injury:

23. Signature: E. E. Symmonds Coroner (M. D. or other)
Address: Memphis Mo Date signed: Dec 24-40

(Licensed Embalmer's Statement on Reverse Side)

## 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.**

No. 2B
4-25-41
I X27852

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State File No. 44023

Registration District No. 810 Primary Registration District No. 6062 Registrar's No.

1. PLACE OF DEATH:
(a) County Scotland
(b) ~~City or town~~ Miller T.P.
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DEACESED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ambrose Sherman Knight
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 widowed
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 76 Months 3 Days 17 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
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) 12-31-40 (Date received local registrar) (b) E. E. Parrish (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 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 , 19; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature E. E. Simmons (Coroner) (M.D. or other)
Address Memphis Mo. Date signed

SUPPLEMENTARY