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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21877

FILED JUL 12 1943

Registration District No. 1984

Primary Registration District No. 5038

Registrar's No. 201

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: 1905 Brookfield Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 44 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58 1 2

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

(d) Street No. 905 Brookfield Ave
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME LAURA-KNOX-ATWOOD

3. (b) If veteran, name war .....

3. (c) Social Security No. None

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed 2

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

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

7. Birth date of deceased Oct (Month) 20 (Day) 1858 (Year)

8. AGE: Years 84 Months 7 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace Fredericksburg - Ohio 1
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business .....

FATHER
12. Name David R. Knox
13. Birthplace Westmoreland Co. Pa 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Louisa Swan
15. Birthplace ..... Pa 1
(City, town, or county) (State or foreign country)

16. (a) Informant W. K. Atwood
(b) Address 3730 Jarboe - K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June - 16 - 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Rose Hill Cemetery - Brookfield

18. (a) Signature of funeral director Hill Funeral Chapel
(b) Address Brookfield Mo.

19. (a) 6-16-1943 (Date received local registrar) (b) W W Cannon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13
year 1943 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 12, 1943, to June 12, 1943;
that I last saw her alive on June 12, 19 ..;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage Apoplexy.	1 week.
Due to	
Due to	
Other condition: Chronic Arthritis (Include pregnancy within 3 months of death)	15 + yr.

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 Roy R Haley (M. D. or other) MD

Address Brookfield Mo. Date signed 6-15-43

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(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 J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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, fact should be so stated above.