

*See also 5-272-43*

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

26297

Do not use this space.

**JUL 17 1943**

1. PLACE OF DEATH

(a) County W. Harrison Registration District No. 336  
 (b) Township W. Commerce Primary Registration District No. 6128 Registered No. 101  
 (c) City West Commerce (d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Malinda Cathern Knight

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State) \_\_\_\_\_  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 2

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas Knight

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6-1871

7. AGE YEARS 72 MONTHS X DAYS X If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Home Repair  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME No Data

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Data

15. MAIDEN NAME No Data

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Data

17. INFORMANT (NAME) Winnie Newhouse  
 (ADDRESS) Rockford, Ill.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mill Spg DATE 7-7- 1943

19. FUNERAL DIRECTOR (NAME) Funeral  
 (ADDRESS) Van Buren

20. FILED 7-6- 1943 Frank H. G. M.D.  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 6 1943

22. I HEREBY CERTIFY, That I attended deceased from June 15, 1943, to July 6, 1943  
 I last saw her alive on July 5, 1943 Death is said to have occurred on the date stated above, at 6 P m.  
 The principal cause of death and related causes of importance were as follows:

myocarditis

fracture of left femur

and

Date of onset 6 mo

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. 161

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) W. T. Eady, M. D.  
 (Address) Commerce, Mo

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.

THIS IS A PERMANENT RECORD

LED 10100

744

RECEIVED

District Health Officer No. 5,

District File Number 743454

Date Filed Nov 15 - 43

OCT 8 1957

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 with the above constitutes grounds for revocation of license.)

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

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 336

Primary Registration District No. 6128

Registrar's No. ....

WRITE PLAINLY, USE ONLY INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town W. Eminence Sup  
(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 Melinda C. 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 W

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 72 Months 10 Days 0 If less than one day..... min.

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

10. Usual occupation

11. Industry or business

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 (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) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death myocarditis

Due to.....

Due to myocarditis

Other conditions Fracture left femur  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence 6-28-43

(c) Where did injury occur? West Eminence Shannon Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home fell out of bed

While at work? no (Specify type of place) (e) Means of injury.....

23. Signature W.T. Creeley (M. D. or other)

Address Eminence, Mo Date signed 7-29-43

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY, USE ONLY INK—MAKE A PERMANENT RECORD

county of

S-26297