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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23522

Registration District No. 236 Primary Registration District No. 6129 Registrar's No.

1. PLACE OF DEATH:

(a) County SHANNON
(b) City or town WEST EMINENCE
(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 WIFE (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County SHANNON
(c) City or town WEST EMINENCE
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MALINDA KATHERINE KNIGHT
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 6
year 1943 hour 6:00 minute P.M.
21. I hereby certify that I attended the deceased from
19 to July 6 1943
that I last saw her alive on 19
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, WIDOW
7. Birth date of deceased NOV 30 1871
(Month) (Day) (Year)

Immediate cause of death MYOCARDITIS
Duration 6 mo

8. AGE: Years 71 Months 7 Days 6
If less than one day hr. min.

Due to MYOCARDITIS JULY 1943

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

Other conditions Fracture of Left Humeral Shaft
(Include pregnancy within 3 months of death) W.T. Emsley
PHYSICIAN

10. Usual occupation House Keeper

Major findings: Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name UNKNOWN
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence 191
(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?

16. (a) Informant Albert Knight
(b) Address Madison T. L. H.
17. (a) BURIAL (b) Date thereof 7-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(Specify type of place)
While at work? (c) Means of injury
23. Signature W.T. Emsley (M. D. or other)
Address Eminence, Mo Date signed 7-12-43

(c) Place: burial or cremation Mill Springs, MO
18. (a) Signature of funeral director Phil A. Fenchel
(b) Address 2625 S. Parker Mo.
19. (a) 7-6-43 (b) W. T. Emsley M.D.
(Date received local registrar) (Registrar's signature)

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

RECEIVED

District Health Officer No. 5,

District File Number 843501

Date Filed 8-23-43

5-26297

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 7-6-43
....., Registered Apprentice No.
working under my personal supervision.

Signed Philip A. Frenchel
Licensed Embalmer No. 2936
P. O. Address Van Buren 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town West Commerce
(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 Life years, months or days

3. (a) PRINT FULL NAME Malinda R. Knight
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 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 Nov. 25 (Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 10 (Less than one day) min.

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

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)
(Burial, cremation, or removal)

(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 July day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration 6 hrs

Due to fracture of L. Humerus

Due to _____

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

Major findings: Of operations _____

Of autopsy 186a
18

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) accident

(b) Date of occurrence 6-24-43

(c) Where did injury occur? at house West Commerce Mo
(City or town) (County) (State)

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

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

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

Address Commerce Mo Date signed 8-29-43

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

SUPPLEMENTARY

S-26297