

FILED JAN 4 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24891

Registration District No. 194

Primary Registration District No. 5710

Registrar's No.

1. PLACE OF DEATH:
(a) County: McDona'd
(b) City or town: Powell *Center twp*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Powell MO.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: McDona'd 60
(c) City or town: Powell MO. 9
(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: Ezra Calvin Knisley
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 14th, year 1943 hour 8 minute 30 A. M.

4. Sex: Male 5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: January 2nd, 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept - 1 - 1943 to Oct - 8 - 1943 that I last saw him alive on Oct - 2 - 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 9 Days 18 If less than one day _____ hr. _____ min.

Immediate cause of death: Angina pectoris
Myocarditis and
Nephritis
Due to _____
Due to _____

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

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

Major findings: 93d
Of operations _____
Of autopsy _____

10. Usual occupation: Farming

MOTHER FATHER {
12. Name: George Knisley
13. Birthplace: ILL (City, town, or county) (State or foreign country)
14. Maiden name: Josephene Shepard
15. Birthplace: ILL (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 _____
(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: Carl Knisley Powell MO.
(b) Address _____
17. (a) Burial (b) Date thereof: 10-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

While at work? _____ (Specify type of place) (Means of injury)
23. Signature: [Signature] (M. D. or other) _____
Address: _____ Date signed: 10/16/43

(c) Place: burial or cremation: Roller Cemetery
18. (a) Signature of funeral director: [Signature]
(b) Address: _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

1290

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

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 3

Registration District No. 194 Primary Registration District No. 5710

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

1. PLACE OF DEATH:
(a) County McDonald
(b) City or town Powell Center, Mo.
(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 _____ years, months or days)

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 _____

3. (a) PRINT FULL NAME Egna Calvin Knisley
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct 1943 year. 20 day. 20 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 _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced sm
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased: Jan (Month) 2 (Day) 1908 (Year)

Duration
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 68 Months 9 Days 9 If less than one day _____ min.
9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

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) (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) April 17-44 (b) O. E. Plummer (Date received local registrar) (Registrar's signature)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

S-42892