

No. 2
1-4-41
17-39
X25390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15919

State File No. _____

Registration District No. 315

Primary Registration District No. 4479

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Queen City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 Schuyler
(c) City or town Queen City
(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 Alice Louisa Knittel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 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 August 22 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 7 13 _____ hr. _____ min.

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

10. Usual occupation house wife

11. Industry or business _____

MOTHER FATHER { 12. Name J. M. Coons
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name _____
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant E. R. Knittel

(b) Address Valley Center Kansas

17. (a) Burial (b) Date thereof April 6 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucasville, Mo

18. (a) Signature of funeral director Wm N. West

(b) Address Lucasville Mo

19. (a) Apr. 6, 1944 (b) A. Justice
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 4
year 1944 hour 9: minute 15 P.M.

21. I hereby certify that I attended the deceased from mar 30 1944 to apr 4 1944
that I last saw h. er alive on apr 4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Embelli Duration 5 day

Due to Solar Meningitis 3

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
100

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature O. P. Young (M.D. or other) DO
Address Queen City Date signed Apr 6

(Licensed Embalmer's Statement on Reverse Side)

1278

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

RECEIVED

District Health Officer No. 10

District File Number 5-44-917

Date Filed MAY 9 1944

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 Wm H West

Licensed Embalmer No. 2882

P. O. Address Queencity

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.