

FILED OCT 24 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33248**
Registrar's No. **4039**

Registration District No. **749**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Childrens' Mercy Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 71 Hours
(Specify whether years, months or days) In this community 71 Hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll 17
(c) City or town Carrollton, Mo. 1
(If outside city or town limits, write "RURAL")
(d) Street No. 601 So. Main Street. 1
(If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clarence Daniel Knott

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Child

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

7. Birth date of deceased: Aug 4 1941
(Month) (Day) (Year)

8. AGE: Years 3 Months 2 Days 4 If less than one day hr. min.

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

10. Usual occupation: Child

11. Industry or business _____

12. Name Clarence Daniel Knott

13. Birthplace Jena Mo
(City, town, or county) (State or foreign country)

14. Maiden name Audrey Ford Knott

15. Birthplace Wakenda Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Daniel Knott

(b) Address Carrollton, Mo.

17. (a) Removal (b) Date thereof 10-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton Mo

18. (a) Signature of funeral director Stanley Turner, Non
(b) Address Carrollton, Mo.

19. (a) Oct 2 1944 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8
year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-5-44
to 10-8- 1944

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Meningitis Duration _____

Due to _____

Due to _____

Other conditions 33
(Include pregnancy within 3 months of death)

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 _____

23. Signature H. M. Hickey (M. D. or other) 0

Address 1624 Prof Date signed _____

361

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

48
283

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..... *Bert W. Gibson*.....

Licensed Embalmer No. *2961*.....

P. O. Address. *Carrollton, 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.