

**FILED JAN 19 1945**  
317

1. PLACE OF DEATH:

(a) County St. Clair  
(b) City or town Osceola  
(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 1  
In this community 35 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair  
(c) City or town Osceola  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Iven Robert Knight

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mvrtle Knight 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased August 15 1875  
(Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 6 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business \_\_\_\_\_

12. Name John Knight

13. Birthplace Moreland Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Moreland

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

16. (a) Informant William H. Knight

(b) Address Osceola Missouri

17. (a) Burial (b) Date thereof 12-24-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Osceola Cemetery

18. (a) Signature of funeral director Osceola Funeral Home

(b) Address Osceola Missouri

19. (a) Dec. 22 1944 (b) T. B. Bradrich  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21  
year 1944 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from 12-15, 1944, to 12-21, 1944;  
that I last saw him alive on 12-21, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 2 wks.

Due to \_\_\_\_\_

Due to 94a

Other conditions (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 \_\_\_\_\_

(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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature T. H. J. Angler, Jr. (M. D. or other) m.d.

Address Osceola Mo. Date signed Dec 22 1944

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

13  
2  
0

1100

AUG 19 1946

District Health Officer No. 7,  
District No. 12-44-1491  
Date Filed 1-11-45

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 Paul Truittone

Licensed Embalmer No. 3990

P. O. Address Oscoda 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.**