

FILED FEB 13 1945  
Registration District No. 225

Primary Registration District No. 4499

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queencity Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
None  
(If not in hospital or institution, write street number or location) 1

(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 98

(c) City or town Queencity 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ (1)

3. (a) PRINT FULL NAME Nannie Agnis Knittle

3. (b) If veteran, name war None

3. (c) Social Security No. Yes

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13  
year 1945 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from January 10, 1945, to January 17, 1945, that I last saw her alive on January 17, 1945; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife J.J. Knittle (dec)

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Aug 20 1862  
(Month) (Day) (Year)

Immediate cause of death Infantile gold age.

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>4</u>	<u>24</u>	_____hr. _____min.

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 162 h

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10. Usual occupation House Wife

11. Industry or business Same

MOTHER FATHER {

12. Name William Snook

13. Birthplace Not Known  
(City, town, or county) (State or foreign country)

14. Maiden name Evelin Ferier

15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Carrie D Edwards

(b) Address Queen City Missouri

17. (a) Burial (b) Date thereof Jan 15, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Queencity Cemetary

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

(b) Address Queencity Mo

19. (a) Jan 13 1945 (b) Ch. D. Justice  
(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 2

23. Signature Ch. D. Justice (M. D. or other) \_\_\_\_\_  
Address Queencity Mo Date signed 1-15-45

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

RECEIVED

District Health Officer No. 10

District File Number 2-45-285

Date Filed FEB 11 1945

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 Self

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

William N West

Licensed Embalmer No. 2882

P. O. Address. Queens City N.Y.

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.