

FILED APR 23 1945
Registration District No. **188**

Primary Registration District No. **5700**

Registrar's No. **1**

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

1. PLACE OF DEATH:

(a) County **Lumpkin**

(b) City or town **Hale** (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Home 3 1/2 Miles N.E. Hale Mo** (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **All her life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lumpkin**

(c) City or town **RFD Hale Mo** (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 **NANNIE E. KNOX**

3. (b) If veteran, name war **No**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **7** year **1945** hour **2:00** minute _____ A.M.

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

6. (b) Name of husband or wife **Arthur H. Knox** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **June 11 1865** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 6** 19 **45** to **March 7** 19 **45** that I last saw her alive on **March 6** 19 **45** and that death occurred on the date and hour stated above.

8. AGE: Years **79** Months **8** Days **26** If less than one day _____ hr. _____ min.

Immediate cause of death **Cerebral Hemorrhage Today**

9. Birthplace **Hale, Mo.** (City, town, or county) (State or foreign country)

Due to _____

Due to _____

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

10. Usual occupation **Housekeeper**

Major findings: _____

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name **G.B. Jacobs**

13. Birthplace **Virginia** (City, town, or county) (State or foreign country)

14. Maiden name **Laura Lewellyn**

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr Jim Jacobs**

(b) Address **Hale Mo**

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? _____

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation **Samera**

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director **Clifford W. Justice**

(b) Address **Jena Mo**

23. Signature **Dr. Oliver A. Blake** (M. D. or other) **D.O.**

Address **Hale, Mo** Date signed **3-8-45**

19. (a) **3-9-1945** (Date received local registrar) (b) **Mrs Van Fullerton** (Registrar's signature)

23 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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Ben 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.