No. 2
9-4-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 15 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34808

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 30

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

1. PLACE OF DEATH:
(a) County Scott County
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 57 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott 100
(c) City or town Sikeston 5
(If outside city or town limits, write "RURAL")
(d) Street No. 122 N. Handy Street ✓
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Minous R Knight
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married /
6. (b) Name of husband or wife Clara Knight
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased December 1 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace Vaig County Ky. 1
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)
16. (a) Informant Wife
(b) Address N. Handy Street
17. (a) Burial (b) Date thereof Oct. 19, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director ✓
(b) Address Sikeston Missouri
19. (a) 10-31-45 (b) Mrs. T. F. Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1945 hour 9 minute 15 A.M.
21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above,

Immediate cause of death Pneumonia ✓

Due to Severe Cold and Asthma.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Orville Taylor Coroner (M. D. or other)
Address Sikeston Mo Date signed 10/18/45

1494

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1145-3188
Date Filed 11-3-45

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 W. C. Croy

Licensed Embalmer No. 3474

P. O. Address Poplar Bluff

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 30

1. PLACE OF DEATH:

(a) County: Scott

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

(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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Minnie R. Knight

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Dec (Month) 1 (Day) 1868 (Year)

8. AGE: Years 77 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 6 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to: Lobar Pneumonia

Due to: Asthma

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy: 10S

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Orville Taylor (Coroner) (M. D. or other)

Address: Sikeston Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

34808