

FILED JAN 25 1946

Registration District No. 43

Primary Registration District No. 3007

State File No.

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Butter  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Long St Hospital  
(If not in hospital or institution, write street number or location)  
(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 Butter  
(c) City or town Poplar Bluff  
(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 JIMMIE LYNN KNIGHT

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

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

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

7. Birth date of deceased Dec 21 1945  
(Month) (Day) (Year)

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

9. Birthplace Poplar Bluff Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Expert

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

12. Name Jimmie Knight

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

14. Maiden name Marion Buchanan

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

16. (a) Informant Jimmie Knight  
(b) Address Wich Mo

17. (a) removed (b) Date thereof 12-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Blair Knight - Stanton  
(b) Address \_\_\_\_\_

19. (a) 1-15-46 (b) RH Murrell  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23,  
year 1945 hour 7 minute 30 p.m.

21. I hereby certify that I attended the deceased from Dec 21, 1945, to Dec 23, 1945,  
that I last saw him alive on Dec 23, 1945,  
and that death occurred on the date and hour stated above.

Immediate cause of death asphyxiation Duration \_\_\_\_\_

Due to cardiac failure

Due to Hydrocephalus

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

23. Signature RH Murrell MD (M. D. or other)  
Address Poplar Bluff, Mo Date signed 1-7-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100074

RECEIVED

District Health Office No. 2

District File Number

146-126

Date Filed

1-22-46

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.