

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **929**

FILED FEB 13 1947

Registration District No. **177**

Primary Registration District No. **3025**

Registrar's No. **23**

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

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: 1
(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 Mo (b) County Howell

(c) City or town West Plains
(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 William Philip Knox

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

6. (b) Name of husband or wife Frances Knox

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased 3 18 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19
year 1947 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 12 Jan 1947 to 19 Jan 1947
that I last saw him alive on 18 Jan 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>10</u>	<u>1</u>	_____ hr. _____ min.

Due to _____

Due to _____

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

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

11. Industry or business Farmer

12. Name Francis Marion Knox

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

14. Maiden name Phoebe Rudence Payne

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

16. (a) Informant Mrs. W. P. Knox

(b) Address South Fork, Mo

17. (a) _____ **(b) Date thereof** 1-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Fork

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) Feb 1 - 1947 **(b)** Beatrice Cook
(Date received local registrar) (Registrar's signature)

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)

(Means of injury) _____

23. Signature Rollin H. Smith (M. D. or other) MD

Address West Plains, Mo **Date** 23/1/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District _____ Member No. 5,

District File Number 24765

Date Filed 2/10/41

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.....

Robert J. Drago....., Registered Apprentice No. 432,
working under my personal supervision.

Signed D. D. Robertson.....

Licensed Embalmer No. 3435

P. O. Address West Plains, 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.