

No. 2
-5-43
5-17-39
X36671

Registration District No. **53**

Primary Registration District No. **3011**

Registrar's No. **207**

1. PLACE OF DEATH:

(a) County Carroll

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

(c) Name of hospital or institution: Bethesda Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days
(Specify whether)

In this community All Life
(years, months or days)

3. (a) PRINT FULL NAME Orlando Jennings Knoderer

3. (b) If veteran, name war NO

3. (c) Social Security No. NO NC

4. Sex Female **5. Color or race** White

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

6. (b) Name of husband or wife H.S. Knoderer

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased July 16 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>11</u>	<u>14</u>	hr. min.

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

10. Usual occupation House Wife

11. Industry or business None

MOTHER, FATHER

12. Name Orlando Jennings

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

14. Maiden name Unknown

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

16. (a) Informant John B. Bickett

(b) Address Carrollton, Mo.

17. (a) (Burial, cremation, or removal) Burial

(b) Date thereof July 7 1947
(Month) (Day) (Year)

(c) Place: burial or cremation St. Carmel

18. (a) Signature of funeral director Marshall C. Ho

(b) Address Carrollton Mo

19. (a) (Date received local registrar) 6/30/47

(b) Registrar's signature Mrs. Herbert Crewe

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

(d) Street No. 207 E. Belmont
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30
year 47 hour 4.30 minute 17 M.

21. I hereby certify that I attended the deceased from June 17, 1947 to June 30 47

that I last saw her alive on June 30, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Pneumonia

Due to Chronic Myocarditis yrs.

Due to Fractured pelvis

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline the cause to which death should be attributed 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?.....

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

23. Signature John B. Bickett (M.D. or other)

Address Carrollton, Mo. **Date signed** 6/30/47

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

8-14-47

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

Frank G. Rea

Registered Apprentice No.

457

working under my personal supervision.

Signed

R. M. Marshall

Licensed Embalmer No.

2525

P. O. Address

Corvettown, 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.

Registration District No. 55

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Ma J. Knoderer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1947 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 186A

Major findings: Of operations _____ id

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 7/47

(c) Where did injury occur? Carrollton Carroll MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home

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

23. Signature _____ (Name of physician or other)

Address Carrollton Date signed Aug 30 1947

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

23030

11/11/11
11/11/11
11/11/11
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11/11/11