S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30229

FILED SEP 16 1947

Registration District No. 2 — Primary Registration District No. 4009 — Registrar's No. 194

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

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town SAVANNAH (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 60 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew 2
(c) City or town SAVANNAH 1 (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME James McKnight
3. (b) If veteran, name war — 3. (c) Social Security No. —
4. Sex M 0 — 5. Color or race W — 6. (a) Single, widowed, married, divorced M /
6. (b) Name of husband or wife Rebecca McKnight — 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased July (Month) 6 (Day) 1864 (Year)

8. AGE: Years 83 — Months 1 — Days 26 — If less than one day ..... hr. ..... min.

9. Birthplace Quitman (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Retired Farmer
11. Industry or business .....

FATHER
12. Name Nelson McKnight /
13. Birthplace Un Known (City, town, or county) Ny. (State or foreign country)

MOTHER
14. Maiden name Betsie Morgan /
15. Birthplace Un Known (City, town, or county) Wiss / (State or foreign country)

16. (a) Informant Mrs. Rebecca McKnight
(b) Address Savannah Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-1947 (Month) (Day) (Year)
(c) Place: burial or cremation SAVANNAH
18. (a) Signature of funeral director E. C. Brett
(b) Address Savannah Mo
19. (a) 9-3-47 (Date received local registrar) (b) Lillian Park (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 2 year 1947 hour 9 minute 35 p. M.
21. I hereby certify that I attended the deceased from July 20 1947 to Sept. 1 1947 that I last saw him alive on Sept. 1 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Cystitis	
Due to Hypertrophied Prostate	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

137A

PHYSICIAN — Underline the cause of 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) 2
While at work? ..... (e) Means of injury .....
23. Signature W. E. Maxwell (M. D. or other) D.O.
Address 307 W. Main, Savannah, Mo. Date signed 9/3/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.