

1. PLACE OF DEATH:

(a) County CLAY  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Excelsior Springs HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution yes, (Specify whether years, months or days) 5 years

3. (a) PRINT FULL NAME LAWSON N. KNIPSCHILD

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Temple KNIPSCHILD 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased AUG 10 1908  
(Month) (Day) (Year)

8. AGE: Years 39 Months 2 Days 13 If less than one day hr. min.

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

10. Usual occupation BANKER

11. Industry or business ←

12. Name JOHN W. Knipschild  
13. Birthplace Carroll County Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Nora M. Craig  
15. Birthplace Carroll County Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Knipschild

(b) Address Hardin Mo.

17. (a) Burial (b) Date thereof Oct. 25/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hardin Mo.

18. (a) Signature of funeral director W. H. ...

(b) Address Excelsior Springs Mo.

19. (a) 10/12/47 (b) Cahoon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24  
(c) City or town Excelsior Springs 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 310 Wildwood 1  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23  
year 1947 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from 9/3/47  
19. to October 23, 1947;  
that I last saw him alive on October 23, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Agranulocytosis Duration 1 1/2 mo.  
Angina

Due to Cause unknown- bacterial infection of teeth- extraction  
Due to of one infected tooth- probable.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 96A  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury ①

23. Signature SR M. ... (M. D. or other) M. D.  
Address Excelsior Springs Mo. Date signed 10/21/47

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-4-57

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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 James A. Molo

Licensed Embalmer No. 3296

P. O. Address Excelsior Spgs 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.