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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41408

FILED JAN 6 1948

Registrar's No. 1073

Registration District No. 2000

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2002 W. Atlantic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution x (Specify whether
In this community life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2002 W. Atlantic 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country x

3. (a) PRINT FULL NAME James Franklin Mc Knight

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

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

6. (b) Name of husband or wife Ida Lee Mc Knight 6. (c) Age of husband or wife if alive x years

7. Birth date of deceased December-9-1860
(Month) (Day) (Year)

8. AGE: Years 87 Months no Days 2 If less than one day x hr. x min.

9. Birthplace Webster County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer & Canner

11. Industry or business Farm

12. Name William Mc Knight

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

14. Maiden name Mary Cloud

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

16. (a) Informant Mrs. Clyde Thomas

(b) Address Marshfield, Missouri

17. (a) Burial (Burial, cremation, or other) (b) Date thereof 12-14-47
(Month) (Day) (Year)

(c) Place: burial or cremation Mission Home

18. (a) Signature of funeral director Flex James

(b) Address Marshfield, Mo.

19. (a) 12-18-47 (Date received local registrar) (b) W. E. Laddley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 11 year 1947 hour 10 minute p.m.

21. I hereby certify that I attended the deceased from October 31 1947 to December 11 1947; that I last saw him alive on December 11 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema Duration 1 week
Due to Chronic Myocarditis 3 years

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

Major findings: Of operations (1) (2) (3) PHYSICIAN
Of autopsy _____
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 0

23. Signature Herbert O. Coffey (M. D. or other) M.D.

Address Springfield, Mo. Date signed 12-18-47

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3312

P. O. Address Springfield, 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.