No. 300
M—10-47
. 5-17-39
D I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 16 1948

Registration District No. 128

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5462

State File No. 39873

Registrar's No. 1057

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Rural ~~[illegible]~~ Franklin Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rt. 1 - Springfield
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 60 years

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

3. (a) PRINT FULL NAME Minnie Maude Knouff
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife David
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased Sept. (Month) 16 (Day) 1879 (Year)

8. AGE: Years 69 Months 2 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace Greene Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Housewife
MOTHER FATHER
12. Name William Price
13. Birthplace ? (City, town, or county) Missouri (State or foreign country)
14. Maiden name Harriet Robards
15. Birthplace ? (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Stella Krasser
(b) Address Rt. 1 Springfield, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-5-48 (Month) (Day) (Year)
(c) Place: burial or cremation Bellview Cem.
18. (a) Signature of funeral director J. W. Klingner & Co.
(b) Address Springfield Mo
19. (a) 12-5-48 (Date received local registrar) (b) W E Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3 year 1948 hour 1 minute 30 p.m.
21. I hereby certify that I attended the deceased from 12-1-1948 to 12-3-1948 that I last saw him alive on 12-1-1948 and that death occurred on the date and hour stated above.

Immediate cause of death: cerebrovascular hemorrhage
Due to: chronic nephritis sudden
Due to:
Other conditions: none
(Include pregnancy within 3 months of death)
Major findings:
Of operations: no
Of autopsy: no

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence none
(c) Where did injury occur? none (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)
While at work? (e) Means of injury

23. Signature S. F. Freeman (M. D.)
Address Springfield Mo Date signed 12/4/48

(Licensed Embalmer's Statement on Reverse Side)

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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.