

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. <u>65</u> | | PRIMARY REG. DIST. NO. <u>4115</u> | | Registrar's No. <u>3</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>CHARITON</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>TRIPLETT</u> | | c. LENGTH OF STAY (In this place) | | c. CITY (If outside corporate limits, write RURAL and give township) <u>21</u> <u>Tripletts</u> | | OR TOWN <u>0 1/2</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u> | | | | d. STREET ADDRESS <u>0</u> <u>1</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>JAMES</u> | | | b. (Middle) <u>HOMER</u> | | c. (Last) <u>KNIGHT</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 18-1949</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>APR. 5-1881</u> | 9. AGE (In years last birthday) <u>67</u> | # UNDER 1 YEAR Months | # UNDER 48 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FEED BUSINESS</u> | | 11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>J. B. KNIGHT</u> | | 13b. MOTHER'S MAIDEN NAME <u>LOUCY MCCULLOUGH</u> | | 14. NAME OF HUSBAND OR WIFE <u>MAMIE E.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mamie E. Knight</u> | | ADDRESS <u>TRIPLETT MO</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Sclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>15 yrs.</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>40</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>D</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>March 23, 1947</u> , to <u>January 14, 1949</u> , that I last saw the deceased alive on <u>January 14, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>H. Stewart, Mch. 0</u> (Degree or title) | | | | 23b. ADDRESS <u>Brunswick, Mo</u> | | 23c. DATE SIGNED <u>1/29/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>1-22-1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>MC CULLOUGH</u> | | 24d. LOCATION (City, town, or county) (State) <u>TRIPLETT MO</u> | |
| DATE REC'D BY LOCAL REG. <u>1-22-49</u> | | REGISTRAR'S SIGNATURE <u>Mildred Boone</u> <u>560</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Marshall</u> | | ADDRESS <u>Brunswick's Mo</u> | |

RECEIVED

District Health Officer No. 8.

District File Number 279

Date Filed 2-3-49

AUG 23 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

L. W. Geisler

Signed _____
Student Embalmer

Licensed Embalmer No. 823

P. O. Address Brunswick 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.