

FILED FEB 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

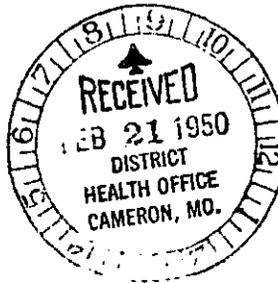
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State File No.

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 32

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| 1. PLACE OF DEATH a. COUNTY <u>Livingston</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe, Missouri</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>327 Mansur</u> | | d. STREET ADDRESS (If rural, give location) <u>327 Mansur</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Bertha</u> | | b. (Middle) <u>B.</u> | |
| | | c. (Last) <u>Knabe</u> | |
| | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 13, 1950</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>April 6, 1966</u> |
| 9. AGE (In years last birthday) <u>83</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 18 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (State or foreign country) <u>Unknown</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| | | 14. NAME OF HUSBAND OR WIFE <u>William Knabe</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | 16. SOCIAL SECURITY NO. _____ | |
| | | 17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____ | |
| 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>Pneumonia, Terminal Bronchial</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>nutritional deficiency</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>3 days</u> <u>20 yrs.</u> <u>4/10X</u> | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | |
| 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.) _____ | |
| 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>Jan. 1, 1946</u> , to <u>Feb. 13, 1950</u> , that I last saw the deceased alive on <u>Feb. 12, 1950</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>Joseph A. Carivad, M.D.</u> | | 23b. ADDRESS <u>Chillicothe, Mo.</u> | |
| | | 23c. DATE SIGNED <u>Feb. 13, 50</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>2-14-50</u> | |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Honey Creek</u> | | 24d. LOCATION (City, town, or county) (State) <u>Grandy Co., Missouri</u> | |
| DATE REC'D BY LOCAL REG. <u>Feb-13-50</u> | | REGISTRAR'S SIGNATURE <u>Frances B. Neill</u> | |
| | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funeral Home</u> ADDRESS <u>Chillicothe, Mo.</u> | |

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



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.

Student
Student Embalmer

Signed *Elton Norman*

Licensed Embalmer No. *4036*

P. O. Address *Chillicothe, 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.