

FILED OCT 18 1950

## STANDARD CERTIFICATE OF DEATH

32489

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>269</u>	
1. PLACE OF DEATH a. COUNTY <u>Row Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		c. LENGTH OF STAY (in this place) <u>5 hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Macon</u>		<u>06/12</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>KCOS Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Coates St. Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Jack</u>		a. (First) <u>Franklin</u>		c. (Last) <u>Knapp</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13, 1950</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>11/25/1948</u>	
9. AGE (In years last birthday) <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>0</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Charles L. Knapp</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Ann Mullinix</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>Charles L. Knapp</u>		ADDRESS <u>Macon, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
II. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Brain Injury, Concussion + Hematoma.</u>		DUE TO (c) <u>Traumatic head injury</u>		<u>7 hrs.</u>	
III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Basal Skull Fracture</u>				<u>7 hrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>161</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>MACON, Macon, MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10/12/1950</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall from chair to Floor</u>			
22. I hereby certify that I attended the deceased from <u>10/12</u> , 19 <u>50</u> , to <u>10/13</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>50</u> , and that death occurred at <u>2:06 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>John W. Wills D.O.</u>				23b. ADDRESS <u>KCOS Hospital</u>		23c. DATE SIGNED <u>10/13/50.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/15/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		24d. LOCATION (City, town, or county) (State) <u>Macon, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-14-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Skinner</u>		ADDRESS <u>Macon, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Date Received: OCT 16 1967  
DISTRICT HEALTH OFFICE #2  
District File Number 10-50-  
Date Filed: OCT 17 1967

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Thos. L. Bost*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4552

P. O. Address Waco, 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.