

FILED JUL 30 1951

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **23865**

BIRTH NO. _____ REG. DIST. NO. **243** PRIMARY REG. DIST. NO. **4363** Registrar's No. **14**

730
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Newton		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Newton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairview Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairview	
c. LENGTH OF STAY (in this place) 5 yrs		d. STREET ADDRESS (If rural, give location) At home	
d. FULL NAME OF HOSPITAL OR INSTITUTION At home			

3. NAME OF DECEASED (Type or Print) a. (First) Benjamin b. (Middle) Harrison c. (Last) Knife			4. DATE OF DEATH (Month) (Day) (Year) June 28 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 20 1888	9. AGE (In years last birthday) 62	10. MONTHS 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME A. P. Knife	13b. MOTHER'S MAIDEN NAME Emily Ott	14. NAME OF HUSBAND OR WIFE Bertha May Knife
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Cleo Daugherty
		ADDRESS Kansas City, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 592x	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 **May 1950**, to **June 28 1951**, that I last saw the deceased alive on **June 20 1951**, and that death occurred at **6 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE O. S. McCall MD	23b. ADDRESS Wheaton Mo	23c. DATE SIGNED 6/29/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/29/51	24c. NAME OF CEMETERY OR CREMATORY Soldiers Cem
		24d. LOCATION (City, town, or county) (State) Jefferson City, Mo.

DATE REC'D BY LOCAL REG. 7-15 1951	REGISTRAR'S SIGNATURE Alpha Byers	25. FUNERAL DIRECTOR'S SIGNATURE Wm Morris Pope	ADDRESS Wheaton Mo
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RECEIVED

NEWTON COUNTY HEALTH UNIT

District Health Officer
District File Number 751-170
Date Filed 7-25-51

NEOSHO, MISSOURI

RECEIVED
JUL 26 1951

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

Wm Morris Payne

Licensed Embalmer No. 7442

P. O. Address Wheelock, 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.