

FILED SEP 14 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28327

850

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2600</u>		Registrar's No. <u>850</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Fair Grove</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Spqfd. Baptist Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Fair Grove</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GROVER</u>		b. (Middle) <u>CLEVELAND</u>		c. (Last) <u>KNEPPER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 4 1953</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>19 Jan. 1885</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>A. J. Knepper</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>Mae Knepper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unkown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mae Knepper</u>		ADDRESS <u>Fair Grove, Missouri</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>Thromia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic nephritis (or nephrosclerosis)</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>about 10 d.</u>  <u>not known but over 6 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION  <u>592X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>8/2</u> , 19 <u>53</u> , to <u>9/4</u> , 19 <u>53</u> that I last saw the deceased alive on <u>9/3</u> , 19 <u>53</u> , and that death occurred at <u>11:30A.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Ray D. Callaway MD</u> (Degree or title)				23b. ADDRESS <u>Springfield Mo</u>		23c. DATE SIGNED <u>9/5/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 6, 53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-8-53</u>		REGISTRAR'S SIGNATURE <u>Edith Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. KLINGNER &amp; CO. Springfield, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed.....  
*Oglesby J. G.*

Licensed Embalmer No. *4176*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.