

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42078**

FILED DEC 28 1953

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>321</u>		
1. PLACE OF DEATH a. COUNTY <u>BOONE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DUNKLIN</u>				
b. CITY OR TOWN <u>COLUMBIA</u>		c. LENGTH OF STAY (in this place) <u>19 DAYS</u>		c. CITY OR TOWN <u>CAMPBELL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ELLIS FISCHEL STATE CANCER HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>ROUTE #2 0350 1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>HIRSH</u>		b. (Middle) <u>OSIE</u>		c. (Last) <u>KNOTTS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 19 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>4-10-77</u>		
9. AGE (In years last birthday) <u>76</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>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13a. FATHER'S NAME <u>JAMES KNOTTS</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JENNIE KNOTTS</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>ELLIS FISCHEL STATE CANCER HOSPITAL</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>CIRRHOSIS OF LIVER</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u> 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. <u>PLEURISY & EFFUSION, LEFT</u> <u>2 WKS.</u>				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) <u>5810</u>				
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>12-18, 1953</u> , to <u>12-19, 1953</u> , that I last saw the deceased alive on <u>12-19, 1953</u> , and that death occurred at <u>6:40 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Wm. J. Gilberg MD</u> (Degree or title)				23b. ADDRESS <u>E. FISCHEL ST. CA. HOSP.</u>		23c. DATE SIGNED <u>12-19-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		24b. DATE <u>12-19-1953</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>CAMPBELL, MO</u>		
DATE REC'D BY LOCAL REG. <u>DEC 19, 1953</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Service, Columbia Mo</u>		ADDRESS _____		

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

Parker Funeral Home - Columbia, Mo. - Campbell, Mo. - Robert Landon F.H. - Campbell, Mo.

(Licensed Embalmer's Statement on Reverse Side)

Remains removed 9 10 am.

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.....
J. W. Phillips

Licensed Embalmer No. *4897*

P. O. Address *Columbus*

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.