

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH
State File No. **43108**

FILED DEC 20 1954

BIRTH NO. _____		REG. DIST. NO. <b>331</b>		PRIMARY REG. DIST. NO. <b>4484</b>		Registrar's No. <b>88</b>	
1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Commerce</b>		c. LENGTH OF STAY (in the place) <b>2 wks</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Neelys Landing 0160</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>at Roy Lee Knight home</b>							
3. NAME OF DECEASED a. (First) <b>WADE</b> (Type or Print)			b. (Middle) <b>SKYLER</b>		c. (Last) <b>KNIGHT</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>DEC 14, 1954</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>AUG 24, 1897</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b>	IF UNDER 14 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labour</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gotling Work</b>		11. BIRTHPLACE (State or foreign country) <b>Neelys Landing Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Andrew Knight</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Walker</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-24-4273</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Price Knight</b> ADDRESS <b>Commerce, Mo</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage 2 days</b>  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. <b>Diabetes Mellitus determined</b>				INTERVAL BETWEEN ONSET AND DEATH          <b>Not</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>331X</b> 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) (Min.) _____		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 <b>Nov 26, 1954</b> , to <b>Dec 12, 1954</b> , that I last saw the deceased alive on <b>Dec 12, 1954</b> , and that death occurred at <b>4:30 P. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Fred W. Martin D.O.</b>				23b. ADDRESS <b>Illmo, Missouri</b>		23c. DATE SIGNED <b>Dec 15-1954</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>12-16-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Hobbs Chapel</b>		24d. LOCATION (City, town, or county) (State) <b>Cape Girardeau County Mo.</b>		
DATE REC'D BY LOCAL REG. <b>Dec 16-54</b>		REGISTRAR'S SIGNATURE <b>Mrs Addie Harves</b> <b>395</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Biglinghoff Funeral Home Illmo, Mo</b> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED \_\_\_\_\_

SCOTT CO. HEALTH DEPT.

DATE RECEIVED DEC 13 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1254-259

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 Oliver Carmick

Licensed Embalmer No. 4470

P. O. Address Illino 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.