

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40214**

FILED DEC 28 1955
BIRTH NO. **89178-55** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1139**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield,		c. CITY OR TOWN Lebanon	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 day		f. STREET ADDRESS (If rural, give location) 0537 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Infant	b. (Middle)	c. (Last) Knight	4. DATE OF DEATH (Month) (Day) (Year) December 19, 1955
-------------------------------------	--------------------------	-------------	-------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH December 18, 1955	9. AGE (In years last birthday) 0 Months 0 Days 1	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	--	---	--	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Lebanon, Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	--

13a. FATHER'S NAME Walter Knight	13b. MOTHER'S MAIDEN NAME Juanita Rhoden	14. NAME OF HUSBAND OR WIFE None
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Walter Knight	ADDRESS Lebanon, Missouri
--	-------------------------	--	----------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH 2 d
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atelectasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Birth		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 7625			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (m.)	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 **12-18**, 19**55**, to **12-19**, 19**55**, that I last saw the deceased alive on **12-19**, 19**55**, and that death occurred at **11 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Cuba Busick, MD	23b. ADDRESS 609 Cherry Springfield Mo 65755	23c. DATE SIGNED 12-19-55
---	---	----------------------------------

24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 20, 1955	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Lebanon, Missouri
--	--------------------------------	--	--

DATE REC'D BY LOCAL REG. 12-21-55	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Palmer General Home Springfield, Mo	ADDRESS
--	---	---	---------

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.....

Not Embalmed

Licensed Embalmer No.....

P. O. Address

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.