

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006415  
STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 200 Primary Registration District No. 5730 Registrar's No. 49

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>New Boston, Drake TWP</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>New Boston, Darke TWP</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at the Home</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>RFD New Boston</u> Residence Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>L.</u> Middle <u>Knapp</u> Last	4. DATE OF DEATH <u>2/17/58</u> Month <u>2</u> Day <u>17</u> Year <u>58</u>
--	---

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------	---------------------------	--	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Framing</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Macon County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	---	---	--

13. FATHER'S NAME <u>Hilman Knapp</u>	14. MOTHER'S MAIDEN NAME <u>Ellen Pryor</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> <u>X</u>	16. SOCIAL SECURITY NO. <u>487-42-6835</u>	17. INFORMANT <u>Anna Bell Knapp, New Boston, Mo.</u> Address
--	--	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Suppression</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--	--

20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____	
---	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
---	---	---

21. I attended the deceased from <u>Feb 1 1955</u> to <u>Feb 17 1958</u> and last saw <sup>her</sup> <u>him</u> alive on <u>Feb 16 1955</u> Death occurred at <u>6:10 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>J.P. Martin</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Browning, Mo.</u>	22c. DATE SIGNED <u>2/19/58</u>
---	-----------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/19/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Boston Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Boston, Macon County, Mo.</u>
---	--------------------------	---	--

24. FUNERAL DIRECTOR <u>Frank K. Kelly</u> ADDRESS <u>Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2/22/58</u>	26. REGISTRAR'S SIGNATURE <u>Keith McNeely</u>
---	---	--

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

County File No. ....  
Date Filed ..... 27. 26. 1918

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 *George W. Davall*

Licensed Embalmer No. *479*

P. O. Address *Kemp*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.