

Harris Knabb

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005185

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. *128*

Primary Registration District No. *2000*

Registrar's No. *165*

300
1-57

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1895 N. Kansas		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1895 N. Kansas		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Last MILLER			4. DATE OF DEATH Month February Day 15 Year 1959		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 December 1887		9. AGE (In years last birthday) 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circus Performer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Miller		13b. MOTHER'S MAIDEN NAME Margaret Young		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) No		16. SOCIAL SECURITY NO. 500-01-5905	17. INFORMANT Address Cora Anderson (Sister) Springfield, Missouri		
18. CAUSE OF DEATH (Only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver, probable Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. myocarditis, chronic 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) _____					INTERVAL BETWEEN ONSET AND DEATH at least 2 weeks at least 2 wks
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 1561		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from Feb 6, 1959 to 2/15/59 and last saw him alive on 2-15-59 . Death occurred at 5:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Harris E. Knabb, M.D. (Degree or title)		22b. ADDRESS 1630 N. Jefferson Springfield, Missouri		22c. DATE SIGNED 2/19/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-18-59	23c. NAME OF CEMETERY OR CREMATORY Highlandville Cemetery		23d. LOCATION (City, town, or county) (State) Highlandville, Missouri	
24. FUNERAL DIRECTOR J.W. KLINGNER & CO. SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 2-19-59	26. REGISTRAR'S SIGNATURE Effie B. Melton		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

word, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

jhc

(Licensed Embalmer's Statement on Reverse Side)

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 *Max Rhodes*

Licensed Embalmer No. *4970*

P. O. Address *Pennsylvania*

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.