

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35599

1. PLACE OF DEATH

County Chariton
Township Salisbury
City Salisbury (No. _____)

Registration District No. 175
Primary Registration District No. 5243

File No. _____
Registered No. 69 St. _____ Ward)

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Nov-26-1930

7. AGE

YEARS ✓

MONTHS ✓

DAYS 2

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER

David W Knight

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Elsie Horton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14. INFORMANT

(Address) David W Knight
Salisbury Mo

15. FILED

11/28 1930 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-28 1930

17. I HEREBY CERTIFY, That I attended deceased from ~~the~~ 11-20, 1930, to 11-28-30 1930, that I last saw her, alive on 11-28-, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Respiratory Paralysis
1603
158
30 minutes (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Intra Cranial Hemorrhage (duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

NO DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Robert Williams M.D.

11/28 1930 (Address) Salisbury Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Bennet Cemetery 11-29 1930

20. UNDERTAKER

ADDRESS

Winkelmeier Bros Salisbury

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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20

21
20
DEC 20 1930

icated by check marks, lacking from the death certificate:

69

Name:

Millie Helen Knight

Who died at:

Chariton Co.

on

Nov. 28, 1930.

Residence: No. _____

St. _____

(If nonresident, city or town)

Length of residence in city or

town where death occurred:

Years _____

Months _____

Days _____

Sex: _____

Color or race: _____

Single, married, widowed or divorced: _____

Date of birth: _____

Age: Years _____

Months _____

Days _____

Occupation: (a) Trade _____

(b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

161 B

Birthplace of mother (State or country) _____

CAUSE OF DEATH:

Respiratory Paralysis

Congenital

Contributory:

Intracranial Hemorrhage

Where was disease contracted? _____

Did operation precede death? _____

Date of _____

What test confirmed diagnosis? _____

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