No. 2
-2-43
17-39
X35397

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

3297

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 9 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 166 Primary Registration District No. 4254 Registrar's No. 8F3

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Knob Noster Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson 51

(c) City or town Knob Noster 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME ANNA LEE Drinkwater

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband ~~or wife~~ Wm. H. Drinkwater

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Dec - 18 - 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months Days 28 If less than one day hr. min.

9. Birthplace Johnson Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Ret. Farm wife

11. Industry or business

FATHER
12. Name Ben Cruse
13. Birthplace Virginia /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Emma Marshall
15. Birthplace Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. H. Drinkwater
(b) Address Knob Noster Mo.

17. (a) City Cem KN (b) Date thereof Jan-19-44
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ City Cem. Knob Noster

18. (a) Signature of funeral director C. L. Sauth
(b) Address Knob Noster Mo.

19. (a) (b)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16
year 44 hour 10 00 minute P.M.

21. I hereby certify that I attended the deceased from Jan 1, 1944 to Jan 16, 1944
that I last saw her alive on Jan 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death (1) Bronchial pneumonia

Due to

Due to

Other conditions (1) Chr. myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

93d

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)
While at work? — (e) Means of injury

23. Signature H. W. Trovsen (M. D. or other)
Address Knob Noster Mo. Date signed Jan 17

1544

(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~~ C. L. Sault

..... ~~Registered Apprentice~~, No.....

working under my personal supervision.

Signed C. L. Sault

Licensed Embalmer No. 1086

P. O. Address Knox Foster Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FEB

State File No. .....

Registration District No. 166 Primary Registration District No. 4254 Registrar's No. ~~13~~ 3

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Knob Noster
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson

(c) City or town Knob Noster
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Anna L. Drinkwater

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Dec (Month) 18 (Day) 1870 (Year)

8. AGE: Years 73 Months Days 28 If less than one day ..... hr. ..... min.

9. Birthplace Johnson Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name Ben Cruse
13. Birthplace ..... (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Emma Marshall
15. Birthplace ..... (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Wm H. Drinkwater
(b) Address Knob Noster Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19-1944 (Month) (Day) (Year)
(c) Place: burial or cremation City Cem. Knob Noster

18. (a) Signature of funeral director C. L. Saults
(b) Address Knob Noster Mo.

19. (a) Jan 17-44 (Date received local registrar) (b) Mrs C. L. Saults (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 16 day
year 1944 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Jan 1, 1944, to Jan 16, 1944
that I last saw her alive on Jan 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(1) Bronchial pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) O Chr. Myocarditis	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature G. W. Grove (M. D. or other) M.D.
Address Knob Noster Mo. Date signed 1-17-1944

SUPPLEMENTARY

FILE

3297