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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10338**

FILED APR 1 1947
Registration District No. **280**

Primary Registration District No. **4421**

Registrar's No. **96**

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

1. PLACE OF DEATH:

(a) County **Platte**

(b) City or town **Parkville** *Peter*

(c) Name of hospital or institution: **at home**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **31 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Platte 83**

(c) City or town **Parkville**

(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country **no**

3. (a) PRINT FULL NAME **Myral Crystal Knight**

(b) If veteran name war **no**

(c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **10** year **1947** hour **1** minute **a** M.

21. I hereby certify that I attended the deceased from **12:45 a.m. Mar 10** to **1 a.m. Mar 10** 19**47**; that I last saw her alive on **Mar 10, 1947**; and that death occurred on the date and hour stated above.

4. Sex **Female**

5. Color of face **white**

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

6. (b) Name of husband or wife **David Mack Knight**

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

7. Birth date of deceased **March 11 1886**

(Month) (Day) (Year)

Immediate cause of death **acute congestive heart failure**

Duration **25 minutes**

Due to **Hypertensive heart disease**

8. AGE: Years **60** Months **11** Days **29**

If less than one day hr. _____ min. _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **Carthage Mo.**

(City, town, or county) (State or foreign country)

Major findings: Of operations **93D**

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation **housewife**

11. Industry or business **home**

12. Name **Robert Moore**

13. Birthplace **Monongahela Pa.**

(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Elizabeth Winkler**

15. Birthplace **Higginsville Mo.**

(City, town, or county) (State or foreign country)

16. (a) Informant **M. D. M. Knight**

(b) Address **Parkville Mo.**

17. (a) **removal** (b) Date thereof **Mar 13-1947**

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Cemetery @ Carthage Mo.**

18. (a) Signature of funeral director **Leland G. Fradette**

(b) Address **Parkville Mo.**

19. (a) **Mar 20-47** (b) **Mrs. Ophelia Rollins**

(Date received local registrar) (Registrar's signature)

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? **0**

(Specify type of place) _____

(e) Means of injury _____

23. Signature **M. D. M. Knight** (M. D. or other) **MD**

Address **Parkville, Mo.** Date signed **12 Mar 47**

MAR 10 1950

DEC 5 1949

DEC 1 1949
DISTRICT HEALTH OFFICE
Cameron, Mo.

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, _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Island G. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville Mo

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