DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 20 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

17252 State File No.

Registration District No. 137 Primary Registration District No. 4217 Registrar's No. 116

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

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Urich
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: at Home in Urich 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
In this community — 75 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry 42
(c) City or town Urich 3
(If outside city or town limits, write "RURAL")
(d) Street No. At Home main St 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joan Lyle Knaus
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex F. 1 | 5. Color or race W. | 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased — 11 (Month) 9 (Day) 1861 (Year)

8. AGE: Years 85 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Cooper Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Homemaker
11. Industry or business —

MOTHER / FATHER
12. Name Henry Knaus
13. Birthplace Howard Co. (City, town, or county) Mo (State or foreign country)
14. Maiden name Jennet Seaton
15. Birthplace (City, town, or county) Maad. (State or foreign country)

16. (a) Informant Leona Knaus
(b) Address Urich Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation Urich Mo
18. (a) Signature of funeral director W. J. Bryan
(b) Address Urich Mo
19. (a) 5-12-47 (Date received local registrar) (b) R A Kenney (Registrar's signature) 1.50

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11, year 1947 hour 3, minute 30 A M.
21. I hereby certify that I attended the deceased from Dec 6, 1946 to May 10, 1947, that I last saw her alive on 5-10, 1947, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Shock result of Fall,
Due to Cerebral Sclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED PHYSICIAN

Major findings:
Of operations X
Of autopsy —

1946

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 42
(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 C

23. Signature J. W. Galbreath (M. D. or other)
Address Urich Mo Date signed 5-12-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 4-427-5-98
Date Filed 5-19-47

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.....

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

working under my personal supervision.

Signed R. R. Kenney

Licensed Embalmer No. 3099

P. O. Address Clinton Mo

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
M—3-45
P 1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

JUN 4 1947

State File No. June 1947

Registration District No. 137 Primary Registration District No. 4217 Registrar's No. 116

1. PLACE OF DEATH:
(a) County Henry (b) City or town Urich
(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 (b) County
(c) City or town
(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 Joan L Krauss
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov 9, 1880
(Month) (Day) (Year)

8. AGE: Years 65 Months Days Unless less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 1 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h... alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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) Accident
(b) Date of occurrence 5-11-47
(c) Where did injury occur? Urich (City or town) Henry (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Home (Specify type of place)
While at work? (e) Means of injury Fall

23. Signature J. W. Galbreath (M. D. or other)
Address Urich Mo Date signed 6-10-47

SUPPLEMENTARY

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

17252