

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

Do not use this space.

15335

1. PLACE OF DEATH

County..... Jackson Registration District No. 399
 Township..... Kaw Primary Registration District No. 1002
 City..... Kansas City (No. St. Lukes Hosp. St. Ward)

File No.
 Registered No. 2205

2. FULL NAME Florence Rodd Knight

(a) Residence, No. Kansas City Kans. 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. 3 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem 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) Jun. 6, 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 11 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At-home
 (b) General nature of industry, business, or establishment in which employed (or employer) ..
 (c) Name of employer ..

9. BIRTHPLACE (CITY OR TOWN) Colorado Springs
 (STATE OR COUNTRY) Colo.

10. NAME OF FATHER E.L. Knight

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY) Colo.

12. MAIDEN NAME OF MOTHER Herma George.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY) Ind.

14. INFORMANT Mrs. H.T. Ferguson.
 (Address) 47th. & Washita K.C.Ks.

15. FILED 5/28. 27 M.M. Crowl
asst REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1927, to Mar. 27, 1927, and that I last saw him alive on Mar. 26, 1927, and that death occurred, on the date stated above, at 1:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Inanition - Eclampsia pregnancy
1420 (duration) yrs. mos. 30 ds.
870 CONTRIBUTORY Paraplegia (Traumatic)
 (SECONDARY) (duration) 4 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? yr DATE OF Mar 8 - 1927
 WAS THERE AN AUTOPSY? yr
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) E.L. Miller M. D.

5/27/1927 (Address) 800 Rall K.C., 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 Forest-Hill DATE OF BURIAL 5/28/1927

20. UNDERTAKER H. W. Gates ADDRESS K.C., Ks.

CAUSE OF DEATH IN PART DETERMINED BY STATEMENT OF OCCUPATION IS VERY IMPORTANT.

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
Township..... Primary Registration District No. 1002 Registered No. 2305
City Stans City (If nonresident give city or town and State) Ward)

2. FULL NAME

Josephine Radd Knight
(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 D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (with the word)

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

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

7. AGE YEARS MONTHS DAYS 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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 5/28/27 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1927

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Maternal ectopic pregnancy
Paralytic analysis traumatic
Paraplegia - Skinned - feet 4 1/2 in
accidental

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....
143 B

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS..... (Signed)....., M. D. , 19 (Address)

*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 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

9-15335