

REC'D MAY 10 1938

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

791

1003

13111

Do not use this space.

## 1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis, Mo.Registration District No.....  
Primary Registration District No.....  
(d) Street No. City Hospital #1Registered No. 3715

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

D-939  
2. PRINT FULL NAME Daniel Knight 5-2-3(a) Residence, No. 2703 Virginia St. 17  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/20/38 195A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Knight22. I HEREBY CERTIFY, That I attended deceased from 4/19/38, 19, to 4/20/38, 19.6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6/17-1883I last saw him alive on 4/20/38, 19. Death is said to have occurred on the date stated above, at 9:00 P.M.7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 54 10. 3

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil  
9. Industry or business in which work was done, as saw mill, bank, etc. Hunting Preserve  
10. Date deceased last worked at this occupation (month and year)..... if Total time (years) spent in this occupation.....

Date of onset

Ulcer of duodenum with uncontrollable hemorrhage12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) City

Other contributory causes of importance:

13. NAME George Knight14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois15. MAIDEN NAME Ida Mueller16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany17. INFORMANT Hosp. info. M. Williams  
(ADDRESS) City Hospital #118. BURIAL, CREMATION, OR REMOVAL  
PLACE Masson Crematory DATE April 23 193819. FUNERAL DIRECTOR (NAME) Thornton  
(ADDRESS) 2906 Gravois Ave20. FILED APR 21 1938 J. F. Breder  
Local RegistrarName of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? No23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury..... 19Where did injury occur?.....  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.Manner of injury.....  
Nature of injury.....24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify.....(Signed) W. Maxwell, M. D.(Address) 1515 Lafayette

**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, .....

*Thos. Lutus*

, or by .....

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

Signed .....

*Thos. Lutus*

Licensed Embalmer No. *1619* —

P. O. Address .....

**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, above space should be left blank.**