

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

24339
 Do not use this space.

1. PLACE OF DEATH **DEAD AUG 8 1938**
 (a) County **Jackson** Registration District No. **399**
 (b) Township **Kaw** Primary Registration District No. **1002** Registered No. **2844**
 (c) City **Kansas City** (d) Street No. **Trinity Lutheran Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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.

2. PRINT FULL NAME **Karl Zeigmer Knox**
 (a) Residence, No. **520** St. **Orlando, Florida**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mary H. Knox**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **August 8, 1885**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	52	11	5	

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

FATHER:

13. NAME **George N. D. Knox**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pennsylvania**

MOTHER:

15. MAIDEN NAME **Martha Zeigmer**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pennsylvania**

17. INFORMANT (NAME) (ADDRESS) **Mrs. Mary H. Knox (Wife)**
Orlando, Florida

18. ~~PLACE OF~~ CREMATION ~~OR~~ ~~BY~~ ~~NAME~~ **Elmwood Crematory**
Kansas City, Mo. DATE **July 14** 19**38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Stine & McClure**
3235 Gillham Plaza, Kansas City

20. FILED **7-14** 19**38** **M. M. Crowe, M.D.**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 13th 1938**

22. I HEREBY CERTIFY, That I attended deceased from **6/22** 19**38** to **7/13** 19**38**
 I last saw him alive on **7/13** 19**38** Death is said to have occurred on the date stated above, at **6 A.** m.

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

Brain tumor (astrocytoma) Date of onset **1937**

Other contributory causes of importance:

Name of operation **Partial removal** Date of **1937**
 What test confirmed diagnosis? **Pathological** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where 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? **no**
 If so, specify (Signed) **James H. Herson** M. D.
 (Address) **907 Fulton Bldg.**

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.

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.....

Licensed Embalmer No.....

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.