REC'D APR 17 1939

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

9570
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kan
(c) City K. C. Mo.
Registration District No. 399
Primary Registration District No. 1002
Registered No. 1176
(d) Street No. St. Mary's 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 252 Miss Nellie K. McKnight
(a) Residence, No. Hickman Mills Mo. St.
(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 Female
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) Dec. 29, 1876
7. AGE YEARS 62 MONTHS 2 DAYS 16 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House keeper
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Kansas City, Kansas

FATHER
13. NAME Robert McKnight
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
15. MAIDEN NAME Margaret Kenney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Mrs Roy Hall 3853 E 60th St.
18. BURIAL, CREMATION, OR REMOVAL
PLACE St Johns Cem K. C. Kansas DATE Mar. 18, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Wagner K. C. Mo.
20. FILED Mch 16, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 15, 1939
22. I HEREBY CERTIFY, That I attended deceased from 3/12, 1939, to 3/15, 1939
I last saw her alive on 3/15, 19.... Death is said to have occurred on the date stated above, at 9:35 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	3/10
107 W	

Other contributory causes of importance:
Ch. Bronchiectasis

Name of operation None Date of
What test confirmed diagnosis? Was there an autopsy? yes

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) [signature], M.D.
(Address) Argyle Bldg.

(Licensed Embalmer's Statement on Reverse Side)

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.