

JAN 13 1940 3999  
Registration District No.

Primary Registration District No. 1002

Registrar's No.

4579

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 1 hr.  
 (Specify whether  
 In this community 35 Yrs. 4 mo  
 years, months or days)

8. (a) PRINT FULL NAME Lucy Knight 5238. (b) If veteran, name war No 8. (c) Social Security No. None4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Thos. J. Knight 6. (c) Age of husband or wife if alive 84 years7. Birth date of deceased Feb. 7th 1878  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
61 61 9 24 hr. min9. Birthplace unknown 9  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife 9

11. Industry or business

12. Name John Mitchell 913. Birthplace unknown 9  
(City, town, or county) (State or foreign country)14. Maiden name unknown 915. Birthplace unknown 9  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Thos. J. Knight(b) Address 4007 E. 17th17. (a) Burial (b) Date thereof Feb 4 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Elmwood18. (a) Signature of funeral director Russ Henderson(b) Address 154 Jackson19. (a) Dec. 1, 1939 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4007 E. 17th St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1st  
year 1939 hour 9 minute 30 A. M.21. I hereby certify that I attended the deceased from  
12-1-39, 19\_\_\_\_, to 1-2-1-39, 19\_\_\_\_;  
that I last saw h. GR alive on Dec. 1st, 1939  
and that death occurred on the date and hour stated above.Immediate cause of death Bremia DurationDue to Bilateral arteriosclerotic nephri-  
is, rt. hydronephosis and hydroureterDue to 131Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: Of operationsOf autopsy See above

## 22. If death was due to external causes, fill in the following:

(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? \_\_\_\_\_

While at work? 1 (Specify type of place) (e) Means of injury \_\_\_\_\_23. Signature P. J. De Maria MD (M. D. or other) \_\_\_\_\_  
Address Supt. K.C. Gen. Hosp. Date signed 12-1-39

RECEIVED BY THE BOARD OF HEALTH

**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 G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address Kansas City

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

42170  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township R.C. Primary Registration District No. 1002 Registered No. 4579  
 (c) City R.C. (d) Street No. \_\_\_\_\_ 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

(a) Residence, No. \_\_\_\_\_ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 1, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
61 9 24

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

OCCUPATION 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.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset

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

Other contributory causes of importance:

FATHER 13. NAME

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

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

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

20. FILED Dec 1, 1939 M. B. Crowe Local Registrar.

If so, specify \_\_\_\_\_ (Signed) P. J. De Maria, M. D.

(Address) St. Louis, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

SUPPLEMENTARY

