DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILE [illegible] 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9680

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 1114

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: 700 West 35th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Life (Specify whether years, months or days)
In this community:

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.: 700 West 35th
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Arthur D McKnight 252
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Helen McKnight
6. (c) Age of husband or wife if alive: 57 years
7. Birth date of deceased: Feb 14 1874 (Month) (Day) (Year)

8. AGE: Years: 65 | Months: | Days: 26 | If less than one day: hr. min.

9. Birthplace: Kansas City Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Retired (Race Horse starter)
11. Industry or business:
FATHER 12. Name: James McKnight
13. Birthplace: Illinois (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Anne Farley
15. Birthplace: Illinois (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: Mrs Thomas Callaway
(b) Address: Ambassador Hotel
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/12/40 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Marys' Cemetery
18. (a) Signature of funeral director: Burk & Cabin Co
(b) Address: 20 West Linwood
19. (a) Mch 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 10th day: March year: 1940 hour: 7 minute: A. M.
21. I hereby certify that I attended the deceased from May 8th, 1940, to May 10th, 1940; that I last saw h. in alive on May 10th, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary disease	24 hrs ?
Due to Arteriosclerosis 9 yrs	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): no
(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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: H. H. Lane (M. D. or other)
Address: 906 Grand ave Date signed: 3-11-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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 Charles M. Quinn

Licensed Embalmer No. 3774

P. O. Address K. C. Mo.

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.