

2
-40
-39
(23159)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34184

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8881

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Wesley Knight

3. (b) If veteran, name war No. 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Pauline 6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased Aug. 21 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 2 5 hr. min.

9. Birthplace Charleston Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Engineer

11. Industry or business Cairo Cake & Meal Co.

12. Name Unk. Knight

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unk. Rail

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pauline Knight

(b) Address Cairo, Ill.

17. (a) Removal (b) Date thereof 10/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mounds, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT 28 1940 (b) J. F. Baird
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County.....
(c) City or town Cairo
(If outside city or town limits, write "RURAL")
(d) Street No. 607 36th. St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 26
year 1940 hour 12:55 minute P. M.

21. I hereby certify that I attended the deceased from Oct 10, 1940
to Oct 26, 1940
that I last saw him alive on Oct 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Carcinoma of Rectosigmoid
Cancer 5 mo.

Due to.....
Due to.....

Other conditions Intestinal Obstruction
(Include pregnancy within 3 months of death) Peritonitis 3 days

Major findings: Carcinoma of Rectosigmoid
Of operations Intestinal Obstruction

Of autopsy Carcinoma of Rectosigmoid
Intestinal Obstruction & Peritonitis
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?

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature E. L. Kays M.D. (M. D. or other)

Address 600 Metropolitan Bldg. Date signed Oct. 27

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.....

J. S. Sullivan

Licensed Embalmer No. *1122*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.