

JAN 8 1941 399

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 5018

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:  
Trinity Lutheran Hospital,  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days,  
 In this community 3 days, (Specify whether years, months or days)

3. (a) PRINT FULL NAME Audis Leslie Knight,  
 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 Minnie Knight, 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased March 10th, 1878  
 (Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 21 If less than one day hr. min.

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

10. Usual occupation Painter,

11. Industry or business X

12. Name Thomas H. L. Knight,

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

14. Maiden name Cobbage,

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

16. (a) Informant's own signature Mrs. Minnie Knight,  
 (b) Address Garnett, Kansas,

17. Removal, (b) Date thereof 12-31-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garnett, Kansas,

18. (a) Signature of funeral director S. J. & McClure,  
 (b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 12-31-40 (b) M. M. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Kansas, (b) County \_\_\_\_\_  
 (c) City or town Garnett,  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? no. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31 - 1940  
 year \_\_\_\_\_ hour 4 minute 40 M.

21. I hereby certify that I attended the deceased from 12-28 40 to 12-31 40, 19\_\_\_\_;  
 that I last saw him alive on 12-31 40, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above,

Immediate cause of death Peritonitis from Perforated gastric ulcer  
 Duration 3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Purge Perforation  
 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) \_\_\_\_\_

(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 M. M. Brown (M. D. or other) \_\_\_\_\_  
 Address 1025 Reubens Bldg Date signed 12-31-40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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**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. J. Allen*

Licensed Embalmer No. *1415-*

P. O. Address *K. C. M. A.*

**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.**