

FILED MAY 5 1943

Registration District No. 179 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 19 ds.
In this community 28 Years
(Specify whether years, months or days)

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. 3033 Euclid Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Carleton Everett Knox

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Ada Frances Knox 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased January 22, 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>2</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Elevator Operator

11. Industry or business Kansas City General Hospital

12. Name John R. Knox

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

14. Maiden name Mary Wood

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

16. (a) Informant Captain Wilbur D. Knox

(b) Address Amarillo, Texas

17. (a) Cremation (b) Date thereof 4-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director John M. Wagner

(b) Address Kansas City, Missouri

19. (a) 4-16-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th
year 1943 hour 5 minute 35 P. M.

21. I hereby certify that I attended the deceased from 2-24-43, 19____, to 4-15-43, 19____; that I last saw him alive on 4-15-43, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial failure

Due to Carcinoma of prostate?
(not confirmed as yet)

Due to _____

Other conditions 518
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of 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 _____ (Specify type of place) (a) Means of injury _____

23. Signature Dr. R. Thorn (M. D. or other) _____

Address Med. Dir. J.C. Gen. Hospital Date signed _____

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

MOTHER FATHER

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

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *Kansas City, Missouri*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1809

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

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:
A. C. General Hospital #1
(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) 7

3. (a) PRINT FULL NAME Carleton Everett Knox
3. (b) If veteran, name war.....
3. (c) Social Security No.....

4. Sex.....
5. Color or race.....
6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife.....
6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
74

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 3/21/43 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(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.?..... years.

20. DATE OF DEATH.....
Month April day 15th
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Acute Myocardial Infarction -
Chronic Cystitis
Chronic Pyelonephritis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy See Above

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)
(c) Means of injury.....
23. Signature Do Eo Walker (M. D. or other) M. D.
W. M. M. M. M. Date signed 3/21/43
Address..... Date signed.....

SUPPLEMENTARY

S-13258