

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **General Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day** (Specify whether)
 In this community **20 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (d) Street No. **710 Virginia** (If rural, give location)
 (e) Citizen of foreign country? (Yes or No) **0**
 If yes, name country

3. (a) PRINT FULL NAME **William McKnight**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **495-24-8534**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **25** year **1945** hour **7** minute **15** P.M.
21. I hereby certify that I attended the deceased from **August 25 45** **to** **August 25 45**
that I last saw him **im** **alive on** **August 25 19 45**
and that death occurred on the date and hour stated above.

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced, or **married**
6. (b) Name of husband or wife **Wanda McKnight** **6. (c) Age of husband or wife if** **42** **alive** **years**
7. Birth date of deceased: (Month) **1898** (Day) (Year)

Immediate cause of death **Chronic cardiac dilatation**
Duration

8. AGE: Years **47** Months **30** Days **0** If less than one day hr. min.

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

10. Usual occupation **Machinist**

11. Industry or business

12. Name **Geo McKnight**

13. Birthplace **Do not know** (City, town, or county) (State or foreign country)

14. Maiden name **Do not know**

15. Birthplace **Do not know** (City, town, or county) (State or foreign country)

16. (a) Informant **Wanda McKnight**

(b) Address **710 Virginia**

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** **Aug 29 45** (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Hope Cemetery K.C.**

18. (a) Signature of funeral director **Raymond Bono**

(b) Address **2117 Ind. Pk. K.C.M.O.**

19. (a) 8-28-45 (Date received local registrar) **(b) Alaudine Holmes** (Registrar's signature)

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **95C²**

Major findings:

Of operations

Of autopsy

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 **Clark W. Sedberry, M.D.** (M.D. or other)

Address **Med. Dir. K.C. General Hospital** (Date signed)

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

17
3
8

016
2911
3581

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: *Deeds Kepley*.....

..... Licensed Embalmer No. *4225*.....

..... P. O. Address. *Indip. 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, fact should be so stated above.