S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39384

FILED JAN 11 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11384

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 6145 Waterman Ave.,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANCES CRAIG KNIGHT.

3. (b) If veteran, name war None.

3. (c) Social Security No. None.

4. Sex Female.

5. Color or race White.

6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Thomas K. Knight, Dec'd.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased September 28, 1864. (Month) (Day) (Year)

8. AGE: Years 81. Months 2. Days 26. If less than one day hr. min.

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

10. Usual occupation At Home.

11. Industry or business

FATHER 12. Name William Craig.
13. Birthplace Winchester, (City, town, or county) Kentucky. (State or foreign country)

MOTHER 14. Maiden name Elizabeth Shewmaker.
15. Birthplace Winchester, (City, town, or county) Kentucky. (State or foreign country)

16. (a) Informant Miss Margaret Knight.
(b) Address 6145 Waterman Ave.,

17. (a) Burial.. (Burial, cremation, or removal) (b) Date thereof 12/26/45. (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.,

18. (a) Signature of funeral director C.R.Lupton & Sons.
(b) Address 7233 Delmar Blv'd.,

19. (a) DEC 26 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1945 hour 2:05 minute a. 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 Lobar Pneumonia

Due to While hospitalized as a result of fall to the floor while she was alone and left by attendant in Sanitarium on Sept 10 1945

Due to Aug 10 '45 Cr.

Duration

Other conditions (Include pregnancy within 3 months of death)

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) Accident
(b) Date of occurrence Sept. 10 1945
(c) Where did injury occur? (City or town) St Louis (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? City Sanitarium (Specify type of place)
While at work? (e) Means of injury Fall

23. Signature (M.D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City, 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.