

No. 2
1/47
17:39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15291**
4640
Registrar's No.

FILED MAY 14 1947
Registration District No. **318**

Primary Registration District No. **1003**

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: **Homer G. Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **21 days**
(Specify whether years, months or days)

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. **1127 N 19th St**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Marshall Knight**

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

4. Sex **Male** Color or race **Colored** 6. (a) Single, widowed, married, divorced..... **9**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **October 22, 1877**
(Month) (Day) (Year)

8. AGE: Years **69** Months **5** Days **13** If less than one day hr. min.

9. Birthplace **New Madrid, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

MOTHER FATHER { 11. Industry or business.....

12. Name **Unknown** 9
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Bettie Hancock**
15. Birthplace **New Madrid, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **George Knight**
(b) Address **4021 Garfield Ave**

17. (a) **Burial** (b) Date thereof **5/8/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New Madrid, Mo**

18. (a) Signature of funeral director **C.W. Roberts**
(b) Address **1416 N. Taylor Ave**

19. (a) **MAY 7 1947** (b) **J. F. Prudek**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5**
year **1947** hour **6** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **4-14**, 19**47** to **5-5**, 19**47**,
that I last saw him alive on **May 5**, 19**47**,
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death **Bronchogenic Carcinoma with Metastasis**
Undet.

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

Other conditions **None**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations.....
Of autopsy **No**
Underline the cause of 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 trade or place) (e) Means of injury.....
23. Signature **E. W. Williams** (D. or other).....
Address **2601 N Whittier** Date signed **5/7/47**

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 318

Primary Registration District No. 1003

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:
(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

Marshall Knight

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased Oct 22 (Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days 10 (if less than one day) hr. min.

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

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) (Date received local registrar) (b) J. F. Bredeck (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1947 hour 12 minute 15 M.

21. I hereby certify that I attended the deceased from 1947 to 1947 that I last saw him alive on May 12 and that death occurred on the date and hour stated above. Immediate cause of death.....

Primary site in Bronchi

Due to.....

Due to.....

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).....

(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. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

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

JUN 12 1947

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