

No. 2  
-12-45  
-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 7 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16580  
Registrar's No. 2199

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: 5049 WORNALL  
(d) Length of stay: 66 YEARS  
In this community 66 YEARS

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County JACKSON  
(c) City or town KANSAS CITY  
(d) Street No. 5049 WORNALL  
(e) Citizen of foreign country? NO  
If yes, name country NO

3. (a) PRINT FULL NAME MRS. ELLA MCKNIGHT WILES  
3. (b) If veteran, name war NO  
3. (c) Social Security No. NO

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife JOHN H. WILES  
6. (c) Age of husband or wife if alive DEC years  
7. Birth date of deceased JULY 26 1860

8. AGE: Years 86-87 Months 9 Days 28  
If less than one day, hr. min.

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

10. Usual occupation HOME

11. Industry or business

MOTHER FATHER  
12. Name JAMES G. MCKNIGHT  
13. Birthplace KY.  
14. Maiden name MARY ANN S. FELTS  
15. Birthplace KY.

16. (a) Informant MRS. GUY M. BABST  
(b) Address 1207 WEST 57 th

17. (a) BURIAL (b) Date thereof 5-26-48  
(c) Place: burial or cremation MT. WASHINGTON

18. (a) Signature of funeral director STINE & MCCLURE  
(b) Address KANSAS CITY, MO.

19. (a) 5-25-48 (b) [Signature] (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MAY day 24  
year 1948 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7-27-48 to 8/24 1948  
that I last saw her alive on 8/24/48  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia  
Due to: Upper respiratory infection and Senility  
Duration 5 days

Other conditions: Changes due to old age  
(Include pregnancy within 3 months of death)

Major findings: Of operations: None  
Of autopsy: None 107  
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?  
(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 [Signature] (M.D. or R.N.)  
Address 209 [Address] Date signed 7/25/48

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

JUN 23 1948

FILED  
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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 Robert A. Reed  
-Licensed Embalmer No. 3745  
P. O. Address K.C. 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.**