

FILED SEP 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28373
7492
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3525 No. Broadway Ave.		26 STREET ADDRESS (If rural, give location) 3525 No. Broadway Ave	
3. NAME OF DECEASED a. (First) Bethany b. (Middle) C. c. (Last) Knight			4. DATE OF DEATH (Month) (Day) (Year) Sept. 1, 1950
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Sept. 30, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Walter Lee Rikard		13b. MOTHER'S MAIDEN NAME Nancy Smith	14. NAME OF HUSBAND OR WIFE Pauline Knight Willis Tom
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Pauline Knight, 3525 No. Broadway Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____		
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H500

22. I hereby certify that I attended the deceased from Aug. 10, 1950, to Sept. 1, 1950, that I last saw the deceased alive on Aug. 22, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Foster	23b. ADDRESS 8209 N. Broadway	23c. DATE SIGNED Sept. 2, 1950
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sept. 2, 1950	24c. NAME OF CEMETERY OR CREMATORY via rail Walnut Grove Cemetery
24d. LOCATION (City, town, or county) (State) Bolivar, Tennessee	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Math Hermann & Son, Inc. 2161 E. Fair Ave.	
DATE REC'D BY LOCAL REG. SEP 2 1950	REGISTRAR'S SIGNATURE J. B. Foster	

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

SEP 12 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Homer W. Jritz

Signed.....
Student Embalmer

Licensed Embalmer No. *3882*

P. O. Address *St. Louis, 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.