

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43612**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11417**

FILED JAN 10 1952

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
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 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 25 1216 N. 8th St. Apt. E	
3. NAME OF DECEASED (Type or Print) a. (First) ALEX b. (Middle) R c. (Last) MC KNIGHT		4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1952	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-28-1882
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 3 Days 11	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Titusville, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Robert McKnight	
13b. MOTHER'S MAIDEN NAME Sarah Unknown		14. NAME OF HUSBAND OR WIFE Helen Unruh McKnight	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 496-36-4514	
17. INFORMANT'S SIGNATURE OR NAME Helen McKnight, above		ADDRESS	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Asthenia Sclerosis 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 checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 330x			
22. I hereby certify that I attended the deceased from 12/10/52 to 12/19/52 , that I last saw the deceased alive on 12/19, 1952 , and that death occurred at 5:20 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wm. E. Smith M.D.		23b. ADDRESS 539 N. Grand.	
23c. DATE SIGNED 12/19/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-12-1952	
24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. DEC 11 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith		ADDRESS Maplewood 17, Mo.	

m86 (Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W.P. Burgess
Licensed Embalmer No. 4029
P. O. Address Maplewood

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.