

FILED AUG 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27444
3851

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY c. LENGTH OF STAY (in this place) 65 YEARS		c. CITY OR TOWN KANSAS CITY d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSPITAL		f. STREET ADDRESS (If rural, give location) 6618 PROSPECT AVENUE	

3. NAME OF DECEASED (Type or Print) a. (First) CYRIL b. (Middle) DUDLEY c. (Last) WARNE KNIGHT			4. DATE OF DEATH (Month) (Day) (Year) AUGUST 4, 1954
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 23, 1882	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work and the number of working life, even if retired) RETIRED CONTRACTOR	10b. KIND OF BUSINESS OR INDUSTRY MASONRY	11. BIRTHPLACE (City and State or Foreign Country) CONWELL, ENGLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JOHN KNIGHT	13b. MOTHER'S MAIDEN NAME ELIZABETH WARNE	14. NAME OF HUSBAND OR WIFE ANNA GERTRUDE KNIGHT
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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. 489-30-6774	17. INFORMANT'S SIGNATURE OR NAME MRS. ANNA GERTRUDE KNIGHT	ADDRESS 6618 PROSPECT AVENUE, KANSAS CITY, MO
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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) Atelectasis		INTERVAL BETWEEN ONSET AND DEATH < 12 hrs
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Subdiaphragmatic abscess		48 hrs
		DUE TO (c) Perforated duodenal ulcer		90 hrs
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right Pyelonephritis due to papullosy, Coninoma of renal pelvis		2-3 Mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION As above - Perf duodenal ulcer	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from 8/1, 1954, to 8/4, 1954, that I last saw the deceased alive on 8/4, 1954, and that death occurred at 8:55 P. m., from the causes and on the date stated above.

23a. SIGNATURE (M.D. or D.O.) Wm. H. Goodson, M.D.	(Degree or title) MD	23b. ADDRESS 730 Prof 159 Kansas City, Mo	23c. DATE SIGNED 8/5/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE AUG-7-1954	24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEM.	24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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DATE REC'D BY LOCAL REG. 8-7-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Newman	ADDRESS 131 BROWN CREEK KANSAS CITY, MISSOURI
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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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 493

P. O. Address H. C. 10, M.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.