

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38481**
Registrar's No. **10118**

FILED DEC 5 1955

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. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN Riverview Gardens	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) ELIAS	b. (Middle) A.	c. (Last) KNIGHT	(Month) (Day) (Year) Nov. 18th, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH June 17th, 1882	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper	10b. KIND OF BUSINESS OR INDUSTRY Cupples Co.	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Knight		13b. MOTHER'S MAIDEN NAME Eleanore Cartmell		14. NAME OF HUSBAND OR WIFE None	
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. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Esther Taylor, 9815 Jeffrey Drive, 15,		
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Leukemia, Acute Monocytic DUE TO (c) Splenomegaly & Dilatation of heart.			INTERVAL BETWEEN ONSET AND DEATH 8 hr. 6-8 mos.
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)	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?		
22. I hereby certify that I attended the deceased from June, 1955 , to Nov. 18, 1955 , that I last saw the deceased alive on Nov. 18, 1955 , and that death occurred at 2:15P m., from the causes and on the date stated above.					
23a. SIGNATURE Norman A. Jones, M.D.		(Degree or title)	23b. ADDRESS 9903 Diamond Dr. (15)		23c. DATE SIGNED 11-19-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/21/55	24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REG. NOV 21 1955	REGISTRAR'S SIGNATURE J. C. Smith M.D.		UNIVERSAL DIRECTOR'S SIGNATURE ADDRESS FUNERAL HOME, INC., St. Louis, 15, Mo.		

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..... *Ralph C. Zinders*.....

Licensed Embalmer No. *427*

P. O. Address *St. Louis*

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.