

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6767

State File No.

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **1577**

BIRTH NO. _____

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 town) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 2833 A. Gamble Street		. STREET ADDRESS (If rural, give location) 21 2833 A. Gamble Street 22190	
3. NAME OF DECEASED (Type or Print) a. (First) Clarence		b. (Middle)	c. (Last) Knox
4. DATE OF DEATH (Month) (Day) (Year) 2 10 56		5. SEX Male	
6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-20-1903
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months 10 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Will Knox	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Evelyn Knox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 362-16-6951	17. INFORMANT'S SIGNATURE OR NAME Evelyn Knox ADDRESS 2833 A. Gamble Street
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart Rt. Bundle Branch Block ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rt. Bundle Branch Block 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 checked="" 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 1-21 , 19 56 , to 2-10 , 19 56 , that I last saw the deceased alive on 2-7 , 19 56 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) S.E. Smith M.D.		23b. ADDRESS 11 No. Jefferson	23c. DATE SIGNED 2-13-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-14-56	24c. NAME OF CEMETERY OR CREMATORY Jackson, Mississippi
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.	
DATE REC'D BY LOCAL REG. FEB 14 1956		REGISTRAR'S SIGNATURE Charles Smith M.D. <i>mjs</i>	

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 *Fulton E. Cecil*.....

Licensed Embalmer No. *198*

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.