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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28684
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6646

| | |
|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐<br>c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hospital #1 — Length of stay in Hospital 30 Years | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY<br>c. CITY OR TOWN ST.LOUIS — Inside Limits Yes X No ☐<br>d. STREET ADDRESS (If outside, give location) 1720 S. Broadway — Reside on Farm Yes ☐ No ☐ |

3. NAME OF DECEASED (Type or print): First Herbert; Middle R.; Last Knight

4. DATE OF DEATH: Month July, Day 15, Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 30, 1893

9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Switchman

10b. KIND OF BUSINESS OR INDUSTRY: Terminal R.R.

11. BIRTHPLACE (City and state or country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

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.: Yes

17. INFORMANT: Alice Knight, 1720 S. Broadway (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the pancreas

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

157.1

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-8-56, to 7-15-56 and last saw him alive on 7-15-56
Death occurred at 12:05p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles E. Hogencamp, M.D. (Degree or title)

22b. ADDRESS 1515 Lafayette

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 7-18-1956

23c. NAME OF CEMETERY St. Trinity Luthern

23d. LOCATION (City, town, or county) St. Louis Co., (State) Missouri

24. FUNERAL DIRECTOR McLAUGHLIN F.H., Inc. ADDRESS 2301 Lafayette

25. DATE RECD. BY LOCAL REG. JUL 16 1956

26. REGISTRAR'S SIGNATURE Earl Smith MD M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed F. G. Farr

Licensed Embalmer No. 3

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.