

Health, Welfare, Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26972
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1821

| | | | | | | | | | |
|---|---------------------------|--|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> COUNTY <u>St. Louis</u> | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Berkeley</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>University City 4356</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hubbartt Nursing H</u> | | | Length of stay in lb <u>2mos</u> | | d. STREET ADDRESS. <u>1070 Purcell</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>Agnes</u> First <u>McKnight</u> Middle <u>Parker</u> Last | | | | 4. DATE OF DEATH <u>July 21, 1957</u> Month <u>July</u> Day <u>21</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 18, 1872</u> | | 9. AGE (In years last birthday) <u>85yrs</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (City and state or country) <u>St. Charles Co., Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>McKnight</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bassett</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mr. Walter E Dean 1070 Purcell</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>331X</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____ | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 <u>7/20/57</u> to <u>7/20/57</u> and last saw her <u>him</u> alive on <u>7/20/57</u> . Death occurred at <u>12:45 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>James J Seely MD</u> | | | | 22b. ADDRESS <u>8924th St Charles Park Rd</u> | | 22c. DATE SIGNED <u>7/22/57</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>July 23, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Alexander Sons - St. Louis</u> | | | 25. DATE RECD. BY LOCAL REG. <u>7/22/57</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert A. Dumble</u> | | | | |

(Licensed Embalmer's Statement on Reverse Side)

51.

Dr. Sales
8924 St. Charles
Ha 8-8100
after 11.

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 *Gas. E. McCallister*

Licensed Embalmer No. *29*

P. O. Address *61758*

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