

Health,  
& Welfare  
Public  
Service

Dr. Maddux

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39980  
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1158

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>Route # 9</b>	
Length of stay in 1b <b>60 Yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARK McKNIGHT</b>			4. DATE OF DEATH Month Day Year <b>Dec. 2 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22 1897</b>
9. AGE (In years to birthday) <b>60</b>		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) <b>Supervisor - Campbell</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Express</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Aaron C. McKnight</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Kirk</b>		14. NAME OF HUSBAND OR WIFE <b>Evelyn McKnight</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>491-03-8202</b>	
17. INFORMANT <b>Mrs. Evelyn McKnight</b>		Address <b>Spfld, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction due to Arteriosclerotic Coronary Thrombosis, 1 month</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Arteriosclerosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <b>Coronary Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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.) <b>none</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>none</b>			
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 <b>11-1-57</b> to <b>12-2-57</b> and last saw him alive on <b>12-2-57</b> Death occurred at <b>7 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W. Paul, M.D.</b>		22b. ADDRESS <b>609 Cherry, Springfield, Mo.</b>	
22c. DATE SIGNED <b>12/2/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/4/57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eastlawn</b>		23d. LOCATION (City, town, or county) <b>Springfield, Mo.</b>	
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>		ADDRESS <b>Springfield, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>12-3-57</b>		26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

AUG 20 1962

JAN 6 1958

DEC 31 1957

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 *Gene Lehmeyer*

Licensed Embalmer No. *4734*  
P. O. Address *Apple, Mo*

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.