

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40437

STATE FILE NUMBER

FILED DEC 2 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5302

S. 300
v. 1-57

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.

Martin J. Mueller USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | |
|---|-------------------------------|---|--|--|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | CITY OR TOWN <u>KANSAS CITY</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>Research Hosp.</u> | | | Length of stay in lb <u>35 YRS</u> | | d. STREET ADDRESS (If outside, give location) <u>4218 FLORA</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rodney</u> Middle <u>H.</u> Last <u>KNIGHT</u> | | | | 4. DATE OF DEATH Month <u>Nov</u> Day <u>-10-</u> Year <u>1957</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 10, 1910</u> | | 9. AGE (In years last birthday) <u>47</u> | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police department</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Policeman</u> | | 11. BIRTHPLACE (City and state or country) <u>Nobel Co, Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>James S. Knight</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Minnie Watson</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Wilma L. Knight.</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> | | 16. SOCIAL SECURITY NO. <u>490-18-5223</u> | | 17. INFORMANT Address <u>Mrs. Wilma Knight. 4218 FLORA.</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>Bleeding esophageal Varices</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cirrhosis of Liver.</u> | | | | | | | 5 1/2 years | |
| DUE TO (c) _____ | | | | | | | 5810 | |
| 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 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 <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>5-12-52</u> to <u>11-10-57</u> and last saw her ^{her} live on <u>11-10-57</u> Death occurred at <u>3:25 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Martin J. Mueller M.D.</u> | | | 22b. ADDRESS <u>535 Angyle Bldg</u> | | | 22c. DATE SIGNED <u>11-11-57</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>NOV-12-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MT. Washington Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Muehlebach</u> | | | ADDRESS <u>6800 Troost</u> | | 25. DATE RECD. BY LOCAL REG. <u>11-11-57</u> | | 26. REGISTRAR'S SIGNATURE <u>Irene Minshall</u> | |



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 *R. E. Nichols*

Licensed Embalmer No. *4997*
P. O. Address *605 W. 7th St. P. O. 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.