

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016035
STATE FILE NUMBER

FILED MAY 1 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4413

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>Centralia - Illinois</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS <u>24 E. Kohl St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA LEE KNUCKLES</u>		4. DATE OF DEATH Month Day Year <u>APRIL 20, 1958</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/2/1924</u>
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Matron</u>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Thomas Wynn</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT Address <u>Norvell Renfro - 608 E. Conick St.</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>CHRONIC AND ACUTE MYELOID LEUKEMIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>204.1</u>			
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.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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.)	
21. I attended the deceased from <u>FEB. 5, 1958</u> to <u>APRIL 20, 1958</u> and last saw her/him alive on <u>APRIL 20, 1958</u> Death occurred at <u>4:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. P. McMillian, M.D.</u> (Degree or title) <u>M. D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>4/21/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23c. NAME OF CEMETERY OR CREMATORY	
23b. DATE <u>4/23/58</u>		23d. LOCATION (City, town, or county) (State) <u>Centralia Illinois</u>	
24. FUNERAL DIRECTOR <u>Jackson Funeral Home 2629 Delmar</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>APR 23 '58</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

PEOPLE'S PUBLIC HEALTH SERVICE

1971

STATE OF

CENTRAL

PHI

DEPT

AC

STATE OF ILLINOIS DEPT OF HEALTH

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 *Leroy G. Sumner*

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.