

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001934

STATE FILE NUMBER

FILED JAN 20 1959

Registration District No. 174 Primary Registration District No. 5644 Registrar's No. 5

300
-57

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Higginsville</u> <u>6540</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Goodloe Home</u>		Length of stay in 1b <u>5 months</u>	d. STREET ADDRESS (If outside, give location) <u>57th. South road</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Cleveland</u> Last <u>Knox</u>			4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</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>Sept. 2, 1885</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>4</u> Day <u>10</u>	IF UNDER 24 HRS. Hours <u>8</u> Min. <u>per.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw mill operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood</u>	11. BIRTHPLACE (City and state or country) <u>Hodge, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John Knox</u>	
13b. MOTHER'S MAIDEN NAME <u>Willie Darnell</u>		14. NAME OF HUSBAND OR WIFE <u>Willie Martin Knox</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>none</u>	
17. INFORMANT <u>Mrs. John Beck</u>		Address <u>Higginsville, Mo.</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>Acute Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Hypertension</u>			<u>10 yel.</u>
DUE TO (c) <u>Atherosclerosis</u>			<u>33 1/2</u> <u>10 yel.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute pulmonary edema - 1 hr.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ to _____ Death occurred at <u>8:15 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>John C. Beltrami</u>		22b. ADDRESS <u>1110 1/2 Main St. Higginsville, Mo.</u>	
22c. DATE SIGNED <u>1-15-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>I-14-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City</u>
23d. LOCATION (City, town, or county) <u>Higginsville Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>F. A. Hoefler</u>		ADDRESS <u>Higginsville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-17-59</u>
26. REGISTRAR'S SIGNATURE <u>Wm. E. Eads</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Fernest R. Hoefler*
4801

Licensed Embalmer No.....

P. O. Address *Higginsville, Missc*

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.