THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015257
STATE FILE NUMBER

FILED MAY 11 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 4018

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): COMMUNITY HOSPITAL — Length of stay in 1b: 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois — b. COUNTY: St. Clair
c. CITY OR TOWN: E.St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1812 St. Louis Ave — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Riley — Middle: — Last: Knight
4. DATE OF DEATH: Month 4 Day 21 Year 59
5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ 2 WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: about
9. AGE (In years last birthday): 85
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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (City and state or country): Mississippi 1
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Boston Knight
14. MOTHER'S MAIDEN NAME: Ellen ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hugh Turner — Address: 215 Bowman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis 331x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 4/23/59 to 4/21/59 and last saw her/him alive on 4/20/59
Death occurred at 8 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Leon H. Kell MD
22b. ADDRESS: 1416 E Broadway
22c. DATE SIGNED: 4/23/59
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 4-24-59
23c. NAME OF CEMETERY OR CREMATORY: Booker Washington
23d. LOCATION (City, town, or county) (State): E. St. Louis, Illinois
24. FUNERAL DIRECTOR: NASH FUNERAL HOME — ADDRESS: 111 N. 13th
M. Frances Nash Mgr.
25. DATE REC'D BY LOCAL REG.: APR 24 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be carefully related. Coroner cannot certify to a death due to natural causes.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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