

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028487

FILED VS SEP 11 1959

Registration District No. 75 Primary Registration District No. 3016 Registrar's No. 73 STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cameron</b>		Length of stay in lb <b>14 Yrs.</b>	c. CITY OR TOWN <b>Cameron</b> 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>Cameron Community Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>423 South Chestnut</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Virgil</b> Middle <b>Edward</b> Last <b>Knight</b>			4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>		11. BIRTHPLACE (City and state or country) <b>Daviess Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>James F. Knight</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Peniston</b>		14. NAME OF HUSBAND OR WIFE <b>Julia A. Knight (Dec'd)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Knight, Gallatin, 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>Carcinoma Gallbladder &amp; Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Not Determined</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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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 _____ a.m. _____ p.m. Month, Day, Year, _____					

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 <b>Cameron Mo</b>	COUNTY	STATE
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21. I attended the deceased from **8-10-59** to **8-26-59** and last saw her <sup>him</sup> alive on **8-26-59**  
Death occurred at **1:45 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>G. H. Hetherton MD</b>	22b. ADDRESS <b>Cameron Mo</b>	22c. DATE SIGNED <b>8-31-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-29-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centenary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Gallatin, Mo.</b>
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24. FUNERAL DIRECTOR <b>R. O. Johnson</b> Hope Funeral Home, Gallatin, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Sept 3-59</b>	26. REGISTRAR'S SIGNATURE <b>Francis Crawford</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed L. O. Lichessou

Licensed Embalmer No. 3302

P. O. Address Ballatin

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