

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1959 3

3010

325

59-031693

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>3 weeks</u>	c. CITY OR TOWN <u>Jackson</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>Southeast Mo. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>612 So. Colorado</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Willis</u> Middle _____ Last <u>KNOX</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1959</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handle Factory</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Handle Mfg.</u>	11. BIRTHPLACE (City and state or country) <u>Shawneetown Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Knox</u>	13b. MOTHER'S MAIDEN NAME <u>Martha McNeely</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	<u>1945</u>
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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>491-16-0969</u>	17. INFORMANT <u>Mrs. Galt Schrader</u>	Address <u>St. Louis, Mo</u>
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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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>
DUE TO (b) _____		
DUE TO (c) _____		

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Fracture right femur

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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.)
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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 checked="" 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 _____
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21. I attended the deceased from 8:15 to Sept. 8, 1959 and last saw him alive on Sept. 7, 1959
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>L. H. Jaeger, M.D.</u> (Degree or title)	22b. ADDRESS <u>Jackson, Mo.</u>	22c. DATE SIGNED <u>9-10-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/10/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson Mo.</u>
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24. FUNERAL DIRECTOR <u>McCombs</u>	ADDRESS <u>JACKSON, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-14-1959</u>	26. REGISTRAR'S SIGNATURE <u>Dennis Kasten</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 4 1959

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 BA Meyer

Licensed Embalmer No. 3057

P. O. Address Jackson

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.