

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS SEP 23 1959

59-032432  
 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4361

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>30 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LUKE'S HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4907 EAST 39TH. STREET</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>R.</b> Last <b>KNIGHT</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>6,</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 7 1902</b>	9. AGE (last birthday) <b>57</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>BARBER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CHESTER NEW HAMPSHIRE USA</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>THOMAS A KNIGHT</b>	13b. MOTHER'S MAIDEN NAME <b>MARY WESTON</b>	14. NAME OF HUSBAND OR WIFE <b>VENUS KNIGHT</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>486 01 7587</b>	17. INFORMANT <b>VENUS KNIGHT 4907 EAST 39th STREET</b>
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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>Auto Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) <u>Coronary Arteriosclerosis</u>	
	DUE TO (c) <u>Cystic Aneurysm Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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

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.	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	COUNTY	STATE
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21. I attended the deceased from <u>1956</u> to <u>Sept. 6 '59</u> and last saw <sup>him</sup> <u>Sept. 5 '59</u> Death occurred at <u>1:55 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>D. W. Newcomer MD</u> (Degree or title)	22b. ADDRESS <u>4635 Wyanzette</u>	22c. DATE SIGNED <u>9-6-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT 8 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY, MO</b>
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24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS, KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>9-8-59</b>	26. REGISTRAR'S SIGNATURE <u>Walter Marshall</u>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF Roblison

**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 Vern Lawler

Licensed Embalmer No. 4912

P. O. Address H. C. M.

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.