

URIAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042098

FILED VS. NOV 16 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9620** STATE FILE NUMBER

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | Length of stay in 1b | c. CITY OR TOWN <u>WEBSTER GROVES</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>ST. JOHN'S HOSP.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>782 TUXEDO BLVD.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH KNOTT</u> | | | 4. DATE OF DEATH Month Day Year <u>OCTOBER 19 1959</u> | | |
| 5. SEX <u>FEMALE</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>JAN. 5 1908</u> | 9. AGE (last birthday) <u>51</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>DAVID J. McKAY</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH O'REILLY</u> | | 14. NAME OF HUSBAND OR WIFE <u>JOSEPH W. KNOTT</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. | 17. INFORMANT Address <u>JOS. W. KNOTT, 782 TUXEDO BL.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Carcinomatosis of Liver</u> | | | | | <u>2 mos.</u> |
| DUE TO (b) <u>Adenocarcinoma of L. Breast metastatic</u> | | | | | |
| DUE TO (c) <u>170x</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 | | COUNTY | STATE |
| 21. I attended the deceased from <u>11/20/44</u> to <u>10/18/54</u> and last saw her alive on <u>10/18/59</u> Death occurred at <u>6:00 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>John Kingrud</u> (Dee or title) | | 22b. ADDRESS <u>689 E Big Bend</u> | | 22c. DATE SIGNED <u>10/19/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>OCT. 21, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u> | |
| 24. FUNERAL DIRECTOR <u>M. J. CROGHAN</u> ADDRESS <u>831 EAST BIG BEND</u> <u>WEBSTER GROVES</u> | | 25. DATE RECD. BY LOCAL REG. <u>OCT 20 '59</u> | | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> <u>m d</u> | |

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed VE Morris

Licensed Embalmer No. 3360

P. O. Address St Louis

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.