

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS
 INDEXED

60-029044

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2248

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis County | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b | c. CITY OR TOWN Kinloch |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5755 Monroe St. |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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|---|----------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last PLAS NMN KNOX | | | 4. DATE OF DEATH Month Day Year July 24, 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-14-1908 | 9. AGE (last birthday) 51 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (City and state or country) Holly Groves, Ark. | | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
| 13a. FATHER'S NAME William Mullin | | 13b. MOTHER'S MAIDEN NAME Mattie Lee | | 14. NAME OF HUSBAND OR WIFE Steven Knox | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address Steven Knox 5755 Monroe St. | | |

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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) CONGESTIVE HEART FAILURE | | INTERVAL BETWEEN ONSET AND DEATH 5 YEARS | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | 5 YEARS |
| DUE TO (c) | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES | | 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 | |
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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 Month, Day, Year 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 |

21. I attended the deceased from **MAY 27, 1948** to **JULY 20, 1960** and last saw her/him alive on **JULY 20, 1960**
 Death occurred at **2:15 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>C. P. Vermillion, M.D.</i> | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 7/25/60 |
|---|--|------------------------------------|

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|--|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-29-60 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery St. Louis County, Mo. | 23d. LOCATION (City, town, or county) (State) |
|--|-----------------------------|---|---|

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| 24. FUNERAL DIRECTOR ADDRESS Metropolitan Funeral System, Inc. 5010 Enright | 25. DATE RECD. BY LOCAL REG. 7-27-60 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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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

John K. Cunningham

Licensed Embalmer No. *14496*

P. O. Address *2405 Main*

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