

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040643

FILED V9 NOV 2 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2939 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo.</u>		Length of stay in 1b <u>165</u>	c. CITY OR TOWN <u>St. Louis</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>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2515 A Hadley</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Charlie Middle Knigh Last Knight 4. DATE OF DEATH Month October Day 5 Year 1960

5. SEX <u>Male</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>6-28-88</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
--------------------	-------------------------------	--	---------------------------------	----------------------------------	--	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>William Knight</u>	13b. MOTHER'S MAIDEN NAME <u>Eleanor Cartmell</u>	14. NAME OF HUSBAND OR WIFE <u>Mattie Knight</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.I.</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT Address <u>Records of Robert Koch Hospital</u>
---	----------------------------------	--

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>? years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic pulmonary emphysema</u>	<u>? years</u>
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic pulmonary tuberculosis

PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  N.  Unknown

19. WAS AUTOPSY PERFORMED? <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 2:10 P.M. Month, Day, Year 4-23-60

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 <u>Robert Koch Hosp., Koch, Mo.</u> COUNTY STATE
--	--	---

21. I attended the deceased from 4-23-60 to 10-5-60 and last saw her him alive on 10-5-60  
Death occurred at 2:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ellis J. Lipson, M.D.</u>	22b. ADDRESS <u>Robert Koch Hosp., Koch, Mo.</u>	22c. DATE SIGNED <u>10-6-60</u>
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-10-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co., Mo.</u>
---	---------------------------	--	---

24. FUNERAL DIRECTOR <u>LEIDNER</u> ADDRESS <u>2223 ST LOUIS</u>	25. DATE RECD. BY LOCAL REG. <u>10-7-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy, 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Albert Maffei

Licensed Embalmer No. 307

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.

17