

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-045400

FILED VS DEC 27 1960 59

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 216

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u>		Length of stay in 1b. <u>1 1/2 months</u>		c. CITY OR TOWN <u>Harrisonville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <u>203 W. Washington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>KNIGHT</u> Last <u>KNIGHT</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1960</u>									
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>Dec 15 1892</u>		9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Cass Co. Mo. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>James Martin Knight</u>				13b. MOTHER'S MAIDEN NAME <u>Susie Sabens</u>				14. NAME OF HUSBAND OR WIFE <u>L. Patience Knight</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. <u>497-40-0085</u>		17. INFORMANT <u>Joel M. Knight</u>		Address <u>Harrisonville, Mo.</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>Peripneumonitis Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 years</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.)									
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>		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>March 1945</u> to <u>12-14-60</u> and last saw her/him alive on <u>12-14-60</u> Death occurred at <u>9:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Edward S. Jones MD</u> (Degree or title)						22b. ADDRESS <u>Harrisonville, Mo</u>			22c. DATE SIGNED <u>12-16-60</u>				
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)					
<u>Burial</u>		<u>Dec 16 1960</u>		<u>Peculiar Cemetery Peculiar</u>				<u>Mo.</u>					
24. FUNERAL DIRECTOR <u>Emmenburgis Harrisonville Mo</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Dec-15-1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Ray Seber</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 Ernest H. Hennenbauer

Licensed Embalmer No. 336

P. O. Address Harrison

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.