

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001472

FILED V8  
FEB 8 1961  
AMENDED

PUBLIC HEALTH AND WELFARE  
 Registrar's District No. 149 Primary Registration District No. 1002 Registrar's No. 337 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>3 years</u>	c. CITY OR TOWN <u>KANSAS CITY</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3642 Central Street</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>3642 Central Street</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <u>JIMMIE LEE KNOWLES</u>	First Middle Last	4. DATE OF DEATH <u>January 19, 1961</u>	Month Day Year
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>Married</u>	8. DATE OF BIRTH <u>9-29-1927</u>	9. AGE (last birthday) <u>33</u>	IF UNDER 1 YEAR Months Days	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) <u>Truckdriver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building material</u>	11. BIRTHPLACE (City and state or country) <u>Unionville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Grover Knowles</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Ida L. Knowles.</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Ida Knowles.</u>	Address <u>3642 Central, Kansas City, Missouri</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u>		<u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Asystole a right cerebral hemisphere.</u>	<u>3 months</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)	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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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>October 16, 1960</u> to <u>Jan 19, 1961</u> and last saw her alive on <u>Jan 19, 1961</u> Death occurred at <u>5:45 p.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>W. Orlando Smith MD</u>	(Degree or title)	22b. ADDRESS <u>K.A. Medical Center</u>	22c. DATE SIGNED <u>1-20-61</u>
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23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	23b. DATE <u>JAN. 20, 1961</u>	23c. NAME OF CEMETERY OR CREMATOR	23d. LOCATION (City, town, or county) <u>UNIONVILLE MISSOURI</u>
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24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons</u>	ADDRESS <u>1331 Brush Cr. 1331 Brush Creek, Kansas City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth S. Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
2  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
9  
INSTEAD OF  
0  
DOCUMENT  
BY AFFIDAVIT OF  
W. Orlando Smith, M.D.  
MEDICAL CERTIFICATION  
SHOULD READ  
ITEM NO.

TITFORKER KIBBON

**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 James W. Stegner

Licensed Embalmer No. 37816

P. O. Address K. C. Mo

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.