

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033241

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 746 Primary Registration District No. 3026 Registrar's No. 467

FILED SEP 26 1961

J. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Independence	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sky View Manor Nursing Home		d. STREET ADDRESS (If outside, give location) 1400 N. River	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ALVIN Middle KNISLEY Last			4. DATE OF DEATH Month September Day 15 Year 1961			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1873	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (City and state or country) Selkirk Canada	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME John L. Knisley	13b. MOTHER'S MAIDEN NAME Elizabeth Swartz	14. NAME OF HUSBAND OR WIFE Margaret Knisley
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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) no none	16. SOCIAL SECURITY NO. none	17. INFORMANT Church Records	Address
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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) Slow Mental and Physical Deterioration DUE TO (b) Deterioration DUE TO (c) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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.) None
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 Independence	COUNTY	STATE
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21. I attended the deceased from **many years** to **Sept 15 1961** and last saw **her** alive on _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John P. Green M.D.	(Degree or title)	22b. ADDRESS 10901 Winner Rd Indep. Mo	22c. DATE SIGNED 9-15-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-18-1961	23c. NAME OF CEMETERY OR CREMATORY Mound Grove	23d. LOCATION (City, town, or county) Independence Missouri	(State)
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24. FUNERAL DIRECTOR Roland R. Speaks	ADDRESS Independence, Mo.	25. DATE RECD. BY LOCAL REG. 9-18-61	26. REGISTRAR'S SIGNATURE Alba L. Craig
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. 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.