

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004052

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1225

FILED FEB 7 1962

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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                |  | c. CITY OR TOWN <u>St. Louis</u>   |  |
| Length of stay in lb   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>1519 E. 14 St.</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>1519 E. 14th St.</u>   |  |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                            |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |

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| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Florence Knox</u> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>1 25 62</u> |  |  |
|--|--|--|--|--|--|

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|-------------------------|---------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><u>Female</u> | 6. COLOR OR RACE<br><u>Col.</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>8-16-1905</u> | 9. AGE (last birthday)<br><u>56</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-------------------------|---------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housekeeper</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u> | 11. BIRTHPLACE (City and state or country)<br><u>Grenada, Miss.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>USAU</u> |
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| 13a. FATHER'S NAME<br><u>Alex Brown</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Ingram</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Sell Knox</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)<br><u>No</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address<br><u>Sell Knox- 1519 E. 14 St.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> |                                    | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>arteriosclerosis</u> |                                  |
|  | DUE TO (c) <u>260x</u>             |                                  |

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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) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><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<br>Hour a.m. p.m.<br>Month, Day, Year | 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 _____ to _____ and last saw her/him alive on _____<br>Death occurred at <u>140 P.</u> 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)<br><u>Helena L. Taylor Coroner</u> | 22b. ADDRESS<br><u>1300 Clark Ave.</u> | 22c. DATE SIGNED<br><u>1-29-62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 23b. DATE<br><u>1-31-62</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Washington Park</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Berkeley, Mo.</u> |
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| 24. FUNERAL DIRECTOR ADDRESS<br><u>A.L. Beal Und.Co.-4303 Delmar</u> | 25. DATE RECD. BY LOCAL REG.<br><u>JAN 29 1962</u> | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith, M.D.</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF

MEDICAL CERTIFICATION  
 DOCUMENT

**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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton Ave

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.