

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028315

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 40

FILED AUG 2 1962

VS 300  
Rev. 4/59

1 0930  
2 23098  
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4 0  
5 1  
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9 4201  
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12 2-0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Clair</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Osceola</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>1 day</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osceola Medical Hosp</b>		d. STREET ADDRESS (If outside, give location) <b>3417 St John</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eloyd E. Knight</b>			4. DATE OF DEATH Month Day Year <b>July 16, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/04</b>
9. AGE (last birthday) <b>58</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	11. BIRTHPLACE (City and state or country) <b>St. Clair Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Knight</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Helmick</b>		14. NAME OF HUSBAND OR WIFE <b>Josephine Knight</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No</b>		17. INFORMANT <b>Harild Knight, K.C. Mo;</b>	
16. SOCIAL SECURITY NO. [Redacted]		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			
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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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 a.m. p.m. 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
21. I attended the deceased from <b>1 July 56</b> to <b>16 July 62</b> and last saw him alive on <b>16 July 62</b>		Death occurred at <b>11:55 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>		22b. ADDRESS <b>Osceola Missouri</b>	22c. DATE SIGNED <b>7/17/62</b>
23b. DATE <b>7/18/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lowry City</b>	23d. LOCATION (City, town, or county) <b>Lowry City Mo.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24. FUNERAL DIRECTOR <b>Goodrich Funeral Home, Osceola Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-19-62</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

AUG 2 1962

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 Paul Twinstone

Licensed Embalmer No. 3990

P. O. Address. Osceola 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.