LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36132

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 9499

or

Village ..... Primary Registration District No. 1003 Registered No. .....

or

City St. Louis (NO. 2404 So. 11th St.; 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jacob Knebel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan. (Month) 8 (Day), 1885 (Year)

7 AGE: 33 yrs. 9 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry business, or establishment in which employed (or employer): [illegible]

9 BIRTHPLACE (City or town, State or foreign country): St. Louis

PARENTS

10 NAME OF FATHER: Frank Knebel

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Emma Kunst

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Knebel

(Address) 2404 So. 11th St.

15 Filed OCT 13 1918, 19 Max C Starkcoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 11 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 4, 1918, to Oct 11, 1918, that I last saw him alive on Oct 10, 1918, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108

91B (Duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) F W Veninga M. D.

Oct 11, 1918 (Address) 3409 S Jefferson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New St. Marcus

DATE OF BURIAL: Oct. 13, 1918

20 UNDERTAKER: Walker-Helderle

ADDRESS: 2331 So. Bway

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... 1.....
(Month) (Day) (Year)

7 AGE
.....yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
....., 191....., to ....., 191.....
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.