LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 701 File No. 36286

or

Village ..... Primary Registration District No. 1008 Registered No. 9658

or

City St Louis (No. St. Anthony Hosp St. 10 Ward)

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

2 FULL NAME Bernard Joseph Kniest, Sr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W.

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

6 DATE OF BIRTH May (Month) 8 (Day) 1844 (Year)

7 AGE 74 yrs. 5 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Printer

(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER Lambert Kniest

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

12 MAIDEN NAME OF MOTHER Unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Kniest

(Address) 1720 Beulah Pl

15 Filed OCT 16 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) — 15 (Day) — 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct-15, 1918, to Oct 15, 1918, that I last saw him alive on Oct-15, 1918, and that death occurred, on the date stated above, at 11.40 PM

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia—(operation)

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) A. J. Raemdonck M. D.

10-16-1918 (Address) 10 N Grand Av

*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. 1 ds. In the State 41 yrs. ..... mos. ..... ds.

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

Former or usual residence 1720 Beulah Pl.

19 PLACE OF BURIAL OR REMOVAL Calvary Cem DATE OF BURIAL Oct 17, 1918

20 UNDERTAKER Mullen Und Co ADDRESS 4069 St Louis Ave

LOCAL REGISTRAR'S REC[illegible] [illegible]OT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township..... Registration [illegible] ..... File No. .....
or
Village ..... Primary Re[illegible] No. ..... Registered No. .....
or
City..... (NO. [illegible] 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.