2

FILED JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19397

Registration District No. 756 Primary Registration District No. ~~4454~~ 5997 Registrar's No. 9 19397

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town Rural - Portage 1 [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.R. #4 - Black Walnut, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town Rural R. #4
(If outside city or town limits, write "RURAL")

(d) Street No. Black Walnut
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Frank Knobbe 510

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of ~~husband~~ or wife Elizabeth Mary Schroeder

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased June (Month) 13 (Day) 1867 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	11	2	hr. min.

9. Birthplace Black Walnut, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Martin Knobbe
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Elizabeth Swellentrop
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Mrs. Elizabeth Knobbe
(b) Address Black Walnut, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 18 - 1940 (Month) (Day) (Year)
(c) Place: burial or cremation St. Francis Cem. Portage Des Sioux, Mo.

18. (a) Signature of funeral director H. C. Dallmeyer & Sons
(b) Address 800 N. Second, St. Charles, Mo.

19. (a) May 17-1940 (Date received local registrar) (b) Rose Barnard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1940 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from May 2, 1940, to May 15, 1940 that I last saw him alive on May 14th, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Arterio Sclerosis - myocarditis chronic	15 years
Due to	
Other conditions (Include pregnancy within 3 months of death) 93C	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

(e) Means of injury

23. Signature C. A. Barnard (M. D. ~~or other~~) 5/6/40

Address Portage Des Sioux, Date signed

Sub. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed John E. Dallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles 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 this body is not embalmed, above space should be left blank.