

JAN 10 1941

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

Jackson  
 (a) County  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

Missouri (a) State (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 4330 Fairmount  
 (d) Street No. (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME ANNA KNEIB

3. (b) If veteran, No name war. 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed  
 6. (b) Name of husband or wife John A. Kneib 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: Mch 27 1876 (Month) (Day) (Year)

8. AGE: 64 Years 8 Months 24 Days If less than one day hr. min.

9. Birthplace Greensburg Indiana (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business Plays laundry

12. Name Jos. Pegbers

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Antoinette Jasper

15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant John J. Kneib

(b) Address 4741 Terrace

17. (a) Burial (b) Date thereof 12/24/40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (e) Signature of funeral director Frank A. Tobin

(b) Address 2121 W. Main

19. (a) Dec. 23, 1940 (b) J. M. Brown (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21st year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct. 29, 1940, to Dec 21, 1940, that I last saw him alive on Dec 21, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarction + hypertensive heart disease.  
 Due to disease.  
 Due to \_\_\_\_\_

Other conditions: Thrombosis of left femoral artery (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy: Thrombosis of left femoral artery + hypertensive heart disease.

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? \_\_\_\_\_

361 (Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature C. C. Casper, M.D. (M. D. or other) Address 2121 W. Main Date signed 12/24/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4871

1. PLACE OF DEATH:

(a) County Mo Jackson  
(b) City or town Jackson City  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits write "RURAL")  
(d) Street No. 4330 Fairmount  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Anna Kneib

3. (b) If veteran, name war..... 3. (c) Social Security No. 486-07-4641

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 64 Months Days If less than one day hr min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Dec 23 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-41478 1940