No. 2
-1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26026

Registrar District No. 757 Primary Registration District No. 3036 5998 Registrar's No. 145

1. PLACE OF DEATH:

(a) County: St. Charles

(b) City or town: St. Charles (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3 miles East of Pieper Bridge (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Michigan (b) County: 999

(c) City or town: Govest 20 (If outside city or town limits, write "RURAL")

(d) Street No.: Rural Route #1 0 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 2

3. (a) PRINT FULL NAME: Harold V. Knapp

3. (b) If veteran, name war: No

3. (c) Social Security No. 306-10-6943

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: January (Month) 8 (Day) 1919 (Year)

8. AGE: Years 22 Months 6 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace: Govest (City, town, or county) / Michigan (State or foreign country)

10. Usual occupation: Aviator

11. Industry or business .....

FATHER
12. Name: Warren Stewart Knapp
13. Birthplace: South Haven (City, town, or county) / Michigan (State or foreign country)

MOTHER
14. Maiden name: Nellie Race Underwood
15. Birthplace: Unknown (City, town, or county) / Kansas (State or foreign country)

16. (a) Informant: Warren Stewart Knapp
(b) Address: RR #1 - Govest, Michigan

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation: Bangor, Michigan

18. (a) Signature of funeral director: N.C. Dallmeyer & Son
(b) Address: 800 N. Second, St. Charles, Mich.

19. (a) 8-7-41 (Date received local registrar) (b) Clarence G. Reuter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7 year 1941 hour 6 minute P. M.

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

Coroner's Case.

Duration

Immediate cause of death: Fracture of Skull + multiple fracture of bones of body

Due to .....

Due to .....

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

Major findings: Of operations —

Of autopsy Yes

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) Coroner's open verdict

(b) Date of occurrence Aug 7 1941 (Month) (Day) (Year)

(c) Where did injury occur? St. Rt. 2 5th mile St. Charles (City or town) (County) (State)

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

While at work? No (e) Means of injury Tail spin at 400 feet

23. Signature: R.P. Ernst Schul (M. D. or other) Coroner

Address: St. Charles Mich. Date signed 8/8/41

(Licensed Embalmer's Statement on Reverse Side)

AUG 21 1943

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, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26026

Registration District No. 757 Primary Registration District No. 3036 Registrar's No.

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3 mi. E. of Meyer Bridge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Harold V. Knapp
3. (b) If veteran, name war
3. (c) Social Security No.

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

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 9 41 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-7-41 (Date received local registrar) (b) Clarence G. Meeler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY