

FILED OCT 10 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31930

Registration District No. 470

Primary Registration District No. #3633

Registrar's No. 131

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mt Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mt. St. Joseph Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 39 days
(Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME William Karl Knechtel

3. (b) If veteran, No name war
3. (c) Social Security No. 572-03-5343

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Hazel Taebert
6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased 4 28 1900
(Month) (Day) (Year)

8. AGE: Years 41 Months 4 Days 10
If less than one day hr. min.

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

10. Usual occupation Electrician
R. E. A.

11. Industry or business R. E. A.

MOTHER FATHER
12. Name Frederick John Knechtel
13. Birthplace Thun Switzerland
(City, town, or county) (State or foreign country)
14. Maiden name Suzanne Agn
15. Birthplace Thun Switzerland
(City, town, or county) (State or foreign country)

16. (a) Informant E. M. Michael Record Clerk
(b) Address Mt Vernon Mo.

17. (a) St Joseph Mo (b) Date thereof Sept-7-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo

18. (a) Signature of funeral director W. D. Pratt
(b) Address Mt Vernon, Mo.

19. (a) 9-7-1941 (b) Registrar's signature
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Andrew
(c) City or town Saratoga
(If outside city or town limits, write "RURAL")
(d) Street No. 411 So. 6th St.
(If rural, give location)
(e) Citizen of foreign country? Not known (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1941 hour 11 minute 55 P.M.
21. I hereby certify that I attended the deceased from 7-30-41
19 to 9-7-41 19
that I last saw him alive on 9-6-41
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis 18 Mo
Due to

Due to
Other conditions: 12/15
(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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature of R. Coffman (M. D. or other) M.D.
Address Mt Vernon Mo Date signed 9/7/41

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

RECEIVED

District Health Officer No. 6,

District File Number 1041-1551

Date Filed OCT 6 1941

OCT 14 1941

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.....

Max Fossett....., Registered Apprentice No. 268
working under my personal supervision.

Signed.....

H D Fossett
Licensed Embalmer No. 2201

P. O. Address Mt Vernon, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31930

Registration District No. 470

Primary Registration District No. 5633

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town St. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(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 _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME William K. Knechtenhofer

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 m

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

7. Birth date of deceased 4-28-1904
(Month) (Day) (Year)

8. AGE: Years 41 Months 4 Days hr. min. _____
(If less than one day)

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-7-1991 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day _____
year 1981 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____, 19____;
that I last saw him/her 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)

(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 _____

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

SUPPLEMENTARY

1941

S-31930