

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26095

State File No. \_\_\_\_\_

FILED JUL 31 1943 317

Primary Registration District No. 6076

Registrar's No. 1710

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Bel Nor  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
2942 Ridgeview Drive  
(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:

(a) State Missouri (b) County St Louis

(c) City or town Bel Nor  
(If outside city or town limits, write "RURAL")

(d) Street No. 2942 Ridgeview Drive  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Chris H Knackstedt

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25  
year 1943 hour 8:15 minute P M.

21. I hereby certify that I attended the deceased from 7-25-43  
7-25-43 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Julia Knackstedt 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 17 17 18 89  
(Month) (Day) (Year)

that I last saw him in alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis  
Arteriosclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

74 - 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation Bank Auditor Retired

11. Industry or business First Natl Bank

MOTHER FATHER { 12. Name Louis Knackstedt

{ 13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Charlotte Schiermeyer

{ 15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Julia S Knackstedt

(b) Address 2942 Ridgeview Dr

17. (a) Burial (b) Date thereof 7 28 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Beiderwieden Funl Home Inc

(b) Address 1936 St Louis Ave

19. (a) JUL 27 1943 (b) G. M. Jones, M.D.  
(Date received local registrar) (Registrar's signature)

23. Signature W. B. Moore (M. D. or other) M.D.

Address 7301 Natural Bridge Date signed 7-26-43

*Normandy Mo*

DEC 1 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

*Matthew J. McLaughlin*

Registered Apprentice No.

*352*

working under my personal supervision.

Signed

*G. W. [Signature]*

Licensed Embalmer No.

*2737*

P. O. Address

*1936 St. Louis Ave*

FEB 19 1945

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.