

FILED DEC 29 1943  
Registration District No. 3438

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Isolation Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10/22/43 to 12/14/43 to  
In this community 12/14/43 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 000  
(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL") 17  
(d) Street No. 5924 Lotus (If rural, give location) 96  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clara Knoll.

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

4. Sex Female 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 June 20 1878  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 5 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Saleslady

MOTHER FATHER

12. Name Adam Knoll

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

14. Maiden name Anna Rauh

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

16. (a) Informant H. Buchanan

(b) Address Isolation Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/43 (Month) (Day) (Year)

(c) Place: burial or cremation Bethania Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966 Easton Ave. St. Louis, Mo.

19. (a) DEC 16 1943 (Date received local registrar) (b) J. A. Brueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 14th year 1943 hour 5 minute 15 A. M.

21. I hereby certify that I attended the deceased from 10/22 to 12/14, 1943

that I last saw her alive on 12-14-43, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration \_\_\_\_\_

Due to pulmonary fibrosis

Due to chronic pulmonary tuberculosis

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy none

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 Dr. Max Well (M. D. or other) \_\_\_\_\_  
Address 5600 Arsenal St. Date signed 12-14-43

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

**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

*Ben Solomon*

Licensed Embalmer No. ....

*4366*

P. O. Address

*St. Louis, 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.**