

#24822

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13006**  
Registrar's No. **3921**

FILED MAY 9 1944 318

1003

Registration District No. ....

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 12 days  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Austan A. Knapp

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

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

7. Birth date of deceased..... SEPTEMBER 9 / 1870  
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 17 If less than one day hr. min.

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

10. Usual occupation NIL

11. Industry or business.....

12. Name HENRY KNAPP

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

14. Maiden name NANCY UNKNOWN

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

16. (a) Informant Mrs Augusta Knapp

(b) Address 4369 Neosha

17. (a) BURIAL (b) Date thereof APRIL 29 / 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director E. J. Schurr

(b) Address 3125 Lafayette

19. (a) APP 2 - 1944 (b) J. J. Medved  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County.....  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4369 Neosha av  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26th  
year 1944 hour 12:25 minute P. M.

21. I hereby certify that I attended the deceased from April 11th  
19 44 to April 26th 19 44  
that I last saw him alive on April 26th 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Colon  
Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy Carcinoma of Colon

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 R. K. Kuehler (M.D. or other) M.D.  
Address 1515 Lafayette Date signed 4/26/44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

**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.....

*Joseph B. Vollmer*

Licensed Embalmer No. *4014*

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.**