

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 25853
Registrar's No. 7598

44935
FILED SEP 14 1945
Registration District No. 318

Primary Registration District No. 1003

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-Mar C. Starbuck
(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 MO (b) County 000
 (c) City or town St. Louis MO
(If outside city or town limits, write "RURAL")
 Street No. 1428 Mallinckrodt St
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Julia Kniefatz

3. (b) If veteran, name war..... 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Frank Kniefatz
 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased January 20 Th 1856
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 30th
 year 1945 hour 5:00 minute A M.

21. I hereby certify that I attended the deceased from 8/11/45
 19, to 8/30/45, 19;
 that I last saw her alive on 8/30/45, 19;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
87 ----- 7 --- 10 --- .hr. --- min.

9. Birthplace Austria Hungaria 11
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name George Houser
 13. Birthplace Austria Hungaria 11
(City, town, or county) (State or foreign country)
 14. Maiden name Not known
 15. Birthplace Austria Hungaria 11
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Kniefatz
 (b) Address 1425 Mallinckrodt Str

17. (a) Burial (b) Date thereof Sep 1 st
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cem, 1945

18. (a) Signature of funeral director Edward Koch
 (b) Address 3516 N 14 Th Str

19. (a) AUG 31 1945 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

Immediate cause of death.....
Arteriosclerotic heart disease
93-
Thrombosis of Abd. Aorta

Due to.....
 Due to.....

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

Major findings:
 Of operations Incarcerated femoral femur

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

23. Signature Missore (M. D. or other) 9-30-48
 Address 1515 Lafayette Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

60
17
9

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

Ronald C. Yokipe

Licensed Embalmer No. *3917*

P. O. Address. *St. Louis*

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.