

#51243
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 21 1945
Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. **39383**
Registrar's No. **10217**

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri.
(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-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
In this community 1 years, months or days (Specify whether)

3. (a) PRINT FULL NAME LOUISE KNAUF
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Abt 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt 75 hr. min. 4

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Michael Hasenfratz 4

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

14. Maiden name Unknown

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

16. (a) Informant George Rinie

(b) Address 2224 Missouri Av.

17. (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S. S. Peter & Paul

18. (a) Signature of funeral director Wm. E. Murrell

(b) Address 1926 Allen A.

19. (a) DEC 10 1945 (b) J. F. Bruner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 2231 Pennsylvania Av. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th
year 1945 hour 10:10 minute A M.

21. I hereby certify that I attended the deceased from 12/5/45
19____ to 12/8/45 19____
that I last saw her alive on 12/8/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism Duration _____

Due to Emboli from pelvic thromboses

Due to hemorrhagic cystitis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy above 1/29

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? W. E. Hamilton Means of injury 12/8/45 MD
(Specify type of place) (M. D. or other)

23. Signature 1515 Lafayette Date signed _____

Address _____

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 L. Johnson

.....
Licensed Embalmer No. 2272

.....
P.O. Address.....

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.