

FILED FEB 7 1946
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **835**

1. PLACE OF DEATH:

(a) County.....
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
LUTHERAN HOSPITAL
(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)

3. (a) PRINT FULL NAME KATHERINE KNESE

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..... ?

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

7. Birth date of deceased NOV. 7 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 2 16 hr. min.

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

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN

12. Name WILLIAM KNESE

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

14. Maiden name MARY WORTMANN

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

16. (a) Informant Miss Anna Knesé

(b) Address 5712 Morganford

17. (a) BURIAL (b) Date thereof JAN 21-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD S.S. Peter & PAULS CEM.

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

(b) Address 3125 LAFAYETTE AV.

19. (a) JAN 25 1946 (b) J. J. Bradrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5712 MORGANFORD
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 46 hour 2:30 minute P.M.

21. I hereby certify that I attended the deceased from Jan 16
1946, to Jan 23 1946

that I last saw her alive on Jan 22 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 6 day

Due to Myocarditis Chronic 1 yr

Due to.....

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

Major findings:
Of operations.....

Of autopsy..... no

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 B. Shanken (M. D. or other)

Address 1514 S. Jefferson Date signed 1/27/46

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 *3125 Lafayette, av*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Feb*

Registration District No. *3/8*

Primary Registration District No. *1003*

Registrar's No. *835*

1. PLACE OF DEATH:

(a) County *St Louis*
(b) City or town *St Louis*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME *Katherine Krese*

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

4. Sex *F* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *s*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years *64* Months *2* Days *6* (Unless than one day) hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country) *mo*

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Jan 25 1946* (b) *J. F. Predeck*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

(Immediate cause of death) _____

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

2715 MAKE A LEGAL COPY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

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