

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. **11327**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2263**

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:
3323 Klein St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ 59 years (Yes or No)
years, months or days)

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. 3323 Klein St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James W. Knapp
3. (b) If veteran, name war World War I 3. (c) Social Security No. 493-09-7798

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 6th
year 1946 hour 5 minute _____ P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mamie Knapp
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased May 13 1886
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>9</u>	<u>23</u>	_____ hr. _____ min.

Immediate cause of death _____
Cortic Meningitis
Due to Cardiac Hypertrophy
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Retired concrete worker
11. Industry or business _____

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name Charles Knapp
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Annie Barrett
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mamie Knapp
(b) Address 3323 Klein St.
17. (a) Burial (b) Date thereof 3-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery
18. (a) Signature of funeral director _____
(b) Address 2117 E. Grand Ave.
19. (a) MAR 8 1946 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____
While at work _____ (c) Means of injury _____
23. Signature Patricia E. Hughes (M. D. or other) _____
Address _____ Date signed 3/10/46

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

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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..... *Frank A. Moore*

Licensed Embalmer No..... *3041*

P. O. Address..... *2117 E. Grand*

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.