

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: St. Anthonys Hos.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 Weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 525 Dover Pl.
(If rural, give location)
 (e) Citizen of foreign country? No
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Christina G. Knopper
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife Geo. H. 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 28 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 4 26 hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business _____

MOTHER FATHER
 12. Name Adam Ulrich
 13. Birthplace Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Anr. Kohr
 15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Olga Knopper
 (b) Address 525 Dover Pl.

17. (a) Entombment (b) Date thereof 3-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Mausoleum

18. (a) Signature of funeral director Jos. P. Fendler Jr.
 (b) Address 7128 Michigan Ave.

19. (a) MAR 25 1946 (b) J. F. Biedenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch. day 24
 year 1946 hour 7 minute 30 P. M.
 21. I hereby certify that I attended the deceased from 3/24/46
 to 3/24/46 1946
 that I last saw her alive on 3/24/46 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Chylothorax, Duph.
Chylothorax, Duph.
 Due to Chylothorax, Duph.

Due to Chylothorax, Duph.
 Other condition Chylothorax, Duph.
(Include pregnancy within 3 months of death)

Major findings:
 Of operations Chylothorax, Duph.
 Of autopsy Chylothorax, Duph.

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 plate)
 (c) Means of injury Chylothorax, Duph.
 23. Signature Alfred E. Gales (M. D. or other)
 Address 609 S. Broadway Date signed _____

Duration
 Physician
 Underline the cause to which death should be charged statistically.

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

10241

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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

Claence Hochow

Licensed Embalmer No.

3093

P. O. Address

7128 Michigan

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.