

FILED JUL 15, 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 22867
Registrar's No. 1480Registration District No. 2Primary Registration District No. 3069

1. PLACE OF DEATH:

- (a) County St. Louis
 (b) City or town Richmond Heights
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Marys Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Infant Knoblauch

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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased July 7, 1947
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
1 hr. _____ min.9. Birthplace Richmond Heights Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name Grant E. Knoblauch
 13. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Kathleen Bigg
 15. Birthplace Marion City Illinois
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Grant E. Knoblauch(b) Address 4225 Juniata St.17. (a) Burial (b) Date thereof 7-8-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation St. Paul Church Yard18. (a) Signature of funeral director Weick Bro. Und. Co.(b) Address 2201 S. Grand Bl.19. (a) 7-10-47 (b) Carol A. Shuff
 (Date received local registrar) (Registrar's signature)

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. 4225 Juniata St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
 year 1947 hour 7 minute A M.21. I hereby certify that I attended the deceased from birth
 _____, 19____, to 7-7, 1947
 that I last saw h. _____ alive on 7-7, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Prematurity (New gestation)Due to Premature rupture of159 membranes

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)
 Means of injury _____23. Signature Joseph A. Shuff (M. D. or other) M.D.
 Address 4962 W. Maryland Date signed 7-7-47

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.....

James R. Dunn

, Registered Apprentice No. 403

working under my personal supervision.

Signed *James R. Dunn*

Licensed Embalmer No. 3722

P. O. Address 2201 S. Grand Bl.

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, above space should be left blank.