S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 15 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25737

Registration District No. #65688 318

Primary Registration District No. 1003

Registrar's No. 7409

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

1. PLACE OF DEATH:

(a) County

(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
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 200

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 6820 Pennsylvania 9
(If rural, give location)

Memorial I

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Charles PETER KNAPP

3. (b) If veteran, name war

3. (c) Social Security No. 490-18-8245

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Corda

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

7. Birth date of deceased Aug (Month) 10 (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	11	26	hr. min.

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

10. Usual occupation Maintenance

11. Industry or business

FATHER
12. Name Not known
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Corda Knapp
(b) Address 6820 Penn.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Cem.

18. (a) Signature of funeral director Fred M. Williams
(b) Address 4435 Wash Ave. Tex

19. (a) AUG 7 1947 (Date received local registrar) (b) J. F. Brekeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 6th
year 1947 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from 8-3-47
19, to Aug. 6th 1947;
that I last saw him alive on Aug. 6th 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Squamous cell carcinoma of the lung with	
Due to: metastases to liver and left axilla	6 mo.
Due to	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	6 mo.

Major findings:
Of operations
Of autopsy

47

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature K. D. Meyer (M. D. or other)

Address 1515 Lafayette Date signed 8/6/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.