

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 Memorial
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Audrey Knott

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

5. Color or race white
4. Sex female
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frank T. Knott
6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased Dec. 2nd 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 8 7 - hr. - min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name Edward Wortmann

13. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Irene Addeheit

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Frank T. Knott

(b) Address 6714 Stratford Ave.

17. (a) burial (b) Date thereof 8-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. AUG 10 1948 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 96
(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")
(d) Street No. 6714 Stratford Ave.
(If rural, give location)
(e) Citizen of foreign country? NR (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year..... hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from 8-7-48
....., 19....., to 8-9-48, 19.....
that I last saw her alive on 8-9-48, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Pulmonary embolism acute
3rd trimester
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Pregnancy, uterine
3rd trimester
Major findings: Post mortem
Of operations: Caesarian Section (Stillborn)
Of autopsy: Same

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 Caron Hendrix M. D. or other MD
Address 1515 Lafayette Avenue Date signed 8-9-48

PHYSICIAN

Underline cause of which death should be charged statistically:

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

MOTHER FATHER

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

Warren A. Carver

Licensed Embalmer No.

3534

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.