

FILED JAN 22 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

829

State File No. ....

BIRTH NO. 1393-51 REG. DIST. NO. 12c PRIMARY REG. DIST. NO. 2000 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> <u>0396</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>OZARK OSTEOPATHIC HOSPITAL</u>		d. STREET ADDRESS (If not, give location) <u>1706 College</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Stanley Paul</u> b. (Middle) <u>KNAPP</u> c. (Last) <u>KNAPP</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1-19-1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>1-9-1951</u>	9. AGE (In years last birthday) <u>9</u>	IF UNDER 1 YEAR Months <u>9</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Greene Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>ROBERT EUGENE KNAPP</u>	13b. MOTHER'S MAIDEN NAME <u>MARGUERITE KATHARIN GROEBKE</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Marguerite K. Knapp</u>	ADDRESS <u>1703 College</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>7645</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute diarrhea</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) <u>unknown</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>premature</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>premature</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1-9, 1951, to 1-17, 1951, that I last saw the deceased alive on 1-17, 1951, and that death occurred at 4:58 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Frank C. Thorne</u> (Degree or title)	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>1/17/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>19 JAN 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>EAST LAWN</u>	24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>
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DATE REC'D BY LOCAL REG. <u>1-19-51</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank C. Thorne</u>	ADDRESS <u>Springfield, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0396

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 \_\_\_\_\_

*Was not externally embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Ralph H. Lewis* \_\_\_\_\_

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo.*

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.