

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35283

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9107

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mo. Baptist Hospital		STREET ADDRESS (If rural, give location) 723 Carroll St. 8	

3. NAME OF DECEASED (Type or Print) a. (First) Meta b. (Middle) c. (Last) Knieste	4. DATE OF DEATH (Month) (Day) (Year) 10/12/51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 26, 1877	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Petersen	13b. MOTHER'S MAIDEN NAME Amelia Beck	14. NAME OF HUSBAND OR WIFE Fred
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alberta Kramer--3244 N. 20th St.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>HYPERTENSIVE - CARDIO-VASCULAR</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>DISEASE (AURICULAR FIBRILLATION)</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>HH 3X</u>
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22. I hereby certify that I attended the deceased from 12-23, 1949, to 10-12, 1951, that I last saw the deceased alive on 10-12, 1951, and that death occurred at 4:22P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George J. Hollman M.D.</u>	23b. ADDRESS <u>812 Olive St. St. Louis</u>	23c. DATE SIGNED <u>10/13/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/16/51	24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REG. OCT 16 1951	REGISTRAR'S SIGNATURE <u>Paul Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Heldule 3634 Gravois</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____
_____, Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Robert Wheeler

Licensed Embalmer No. 2128

P. O. Address Harris 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.