

FILED MAY 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17197**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4362**

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) St. Louis		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) 7 5738 Era Ave.,		267%	
3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) A. c. (Last) Knapp		4. DATE OF DEATH (Month) (Day) (Year) May 13th, 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 21/1903
9. AGE (In years last birthday) 51	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Extract Worker	10b. KIND OF BUSINESS OR INDUSTRY Warner-Jenkinson	11. BIRTHPLACE (City and State or Foreign Country) Arcola, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Lilburn Knapp	
13b. MOTHER'S MAIDEN NAME Luana McGehee		14. NAME OF HUSBAND OR WIFE Leona Knapp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 497-05-4417	
17. INFORMANT'S SIGNATURE OR NAME Leona Knapp		ADDRESS 5738 Era Ave.,	

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative cardiac failure.		INTERVAL BETWEEN ONSET AND DEATH ?
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. arteriosclerosis both coronary arteries.		
	DUE TO (b) _____ 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 Chronic cholecystitis + cholelithiasis		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)	
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? 584x	

22. I hereby certify that I attended the deceased from Feb. 27, 1954 to May 13, 1954, that I last saw the deceased alive on Feb. 13, 1954, and that death occurred at 730 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **William H. Grundmann, M.D.** 23b. ADDRESS **3118 N. Grand St. St. Louis** 23c. DATE SIGNED **5/14/54**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **May 16th, 1954** 24c. NAME OF CEMETERY OR CREMATORY **Roselawn Cemetery** 24d. LOCATION (City, town, or county) (State) **Charleston, Illinois**

DATE REC'D BY LOCAL REG. **MAY 15 1954** REGISTRAR'S SIGNATURE **J. Carl Smith, M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **Leidner Und. Co.,** ADDRESS **2223 St. Louis Ave.,**

G.P. (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....

Licensed Embalmer No. *3749*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.