

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24805

FILED AUG 2 1954

State File No. 6946

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) _____		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"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL				e. STREET ADDRESS (If rural, give location) 24 3511 So. 2nd St. 22490			
3. NAME OF DECEASED (Type or Print) a. (First) FIDELIS		b. (Middle) JOHN		c. (Last) KNAPP		4. DATE OF DEATH (Month) (Day) (Year) JULY 26, 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 7th 1877	
				9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months _____	
						IF UNDER 24 HRS. Days _____	
						Hours _____	
						Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Worker Terminal				10b. KIND OF BUSINESS OR INDUSTRY R.R.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY? _____							
13a. FATHER'S NAME Peter Knapp		13b. MOTHER'S MAIDEN NAME Catherine Unknown		14. NAME OF HUSBAND OR WIFE Viola Knapp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Spanish War		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Viola Knapp 3511 So. 2nd St.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Lobar Pneumonia</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Suppurative Parotitis</i> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>590x</i>			
22. I hereby certify that I attended the deceased from <i>6-29-54</i> , 19____, to <i>7-26-54</i> , 19____, that I last saw the deceased alive on <i>7-26-54</i> , 19____, and that death occurred at <i>8:30P</i> m., from the causes and on the date stated above.							
23a. SIGNATURE <i>Martin H. Austin M.D.</i> (Degree or title)				23b. ADDRESS <i>1515 Lafayette Avenue</i>		23c. DATE SIGNED <i>7-27-54</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>National</i>		24b. DATE <i>7-30-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Jefferson Barracks Mo.</i>	
DATE REC'D BY LOCAL REG. <i>JUL 27 1954</i>		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>KRIEGSHAUSER 4228 So. Kingshighway</i>			

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 *Edwin A. M. DeWitt*.....

Licensed Embalmer No. 309.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**