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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35753
STATE FILE NUMBER

FILED OCT 16 1956

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8520

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Warren
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St, Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Warrenton 1090 1 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital — Length of stay in 1b 1 Week	d. STREET ADDRESS Rural Route (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First Johanna	Middle F	Last Knapheide	4. DATE OF DEATH	Month Sep	Day 12	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Sep 13, 1892	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Warren County Mo			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hasenjaeger			14. MOTHER'S MAIDEN NAME Frederika Wippelmann				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Otto Knapheide	Address Warrenton Mo			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized Peritonitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Ruptured diverticulum of Sigmoid

DUE TO (c) Intussusception of Sigmoid into Rectum & Colon

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 153X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from Sept-5-56 to Sept-12-56 and last saw her/him alive on Sept-12-56

Death occurred at 9:30 P.m m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] — 22b. ADDRESS 4501 a Manchester — 22c. DATE SIGNED Sept-14-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal — 23b. DATE 9-13-56 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION (City, town, or county) Holstein Mo (State)

24. FUNERAL DIRECTOR Albert H. Hoppe — ADDRESS 4700 Washington — 25. DATE RECD. BY LOCAL REG. SEP 14 1956 — 26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John L Denne

Licensed Embalmer No. 4.1

P. O. Address St. Lo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.