

FILED MAR 18 1957

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

10554

STATE FILE NUMBER

1850

Registration District No. 318 Primary Registration District 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 Jefferson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN DeSoto		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION Deaconess ( )			Length of stay in 1b 5 Days		d. STREET ADDRESS 601 Jefferson		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Harrison N.M.N. Knapp				4. DATE OF DEATH Month Day Year Feb. 22, 1957			
5. SEX O M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1892		9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Gen'l. Farm.		11. BIRTHPLACE (City and state or country) Jefferson Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Solomon Knapp				14. MOTHER'S MAIDEN NAME Nancy Gideon			
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 Address Virginia McClanahan DeSoto, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of prostate Metastatic carcinoma of prostate Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>6 1/2 years in 2nd Army</i> DUE TO (c) <i>2-4-57</i>							INTERVAL BETWEEN ONSET AND DEATH 8 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pathological fracture of rt femur.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fall at home Fall at home 177 HF					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. 2-17-57 2-17-57							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office, etc.) Home		20f. CITY, TOWN, OR LOCATION DeSoto		COUNTY STATE DeSoto 1770	
21. I attended the deceased from 2-18-57 6:10 A.M. 2-22-57 and last saw her alive on 2-21-57 Death occurred at 6:10 a m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Geo. E. Scheer (Degree or title) M.D.				22b. ADDRESS 634 N. Grand Ave		22c. DATE SIGNED 2-22-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/24/57	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) DeSoto Mo.		
24. FUNERAL DIRECTOR ADDRESS J. Lee Mothershead DeSoto, Mo.				25. DATE RECD. BY LOCAL REG. FEB 25 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
ServiceS. 300  
1-56

All diseases 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

Securing the medical certification in the specific manner required by this form is the responsibility of the medical certifier.

MAR 26 1957

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 *J. Lee Mathershead*

Licensed Embalmer No. *355*

P. O. Address *Dr. Sato*

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.