

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019215
STATE FILE NUMBER

FILED MAY 19 1958 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 222

S. 300
1-57
804

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| 1. PLACE OF DEATH a. COUNTY <u>Pettis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Sedalia</u> <u>0804</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>830 E. 13</u> | | Length of stay in lb <u>5 years</u> | d. STREET ADDRESS (If outside, give location) <u>830 E. 13</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy F. Knoche</u> | | | 4. DATE OF DEATH Month Day Year <u>May 11, 1958</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 10, 1884</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9. AGE (In years last birthday) <u>74</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Ohio 1</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>usa</u> | | 13. NAME OF HUSBAND OR WIFE <u>Louis H. Knoche</u> | |
| 13a. FATHER'S NAME <u>Frank Wardell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katherine Williams</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. L. G. Koeller</u> | | Address <u>830 E. 13</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>3 yrs.</u> <u>3 yrs.</u> <u>3 yrs.</u> <u>1 yr.</u> |
| DUE TO (b) <u>Hypertension</u> | | | |
| Arterio-Sclerosis | | | |
| Diabetes Mellitus | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Obesity</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 <u>6-1956</u> to <u>5-11-58</u> and last saw her alive on <u>5-11-58</u> Death occurred at <u>4:10 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Frances B. Taylor</u> (Deputy Registrar) | | 22b. ADDRESS <u>M.D. Sedalia, Mo.</u> | 22c. DATE SIGNED <u>5-12-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>May 12, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Hammoud, Ind.</u> |
| 24. FUNERAL DIRECTOR <u>W. Laughlangalis</u> | | ADDRESS <u>519 So Ohio</u> | 25. DATE RECD. BY LOCAL REG. <u>May 12, 1958</u> |
| 26. REGISTRAR'S SIGNATURE <u>Frances Shelby By Deputy Betty Yeager</u> | | | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

MAY 19 1958

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 *H.P. McLeary*

Licensed Embalmer No. *3153*

P. O. Address *Sedalia 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.