

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003164

STATE FILE NUMBER

FILED FEB 11 1959

Registration District No. ....

318

Primary Registration District No. ....

1003

Registrar's No. ....

113

300  
-57 C  
15  
35

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>ST. LOUIS</i>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <i>4000 SAPPINGTON</i>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <i>ST. JOHN'S HOSPITAL</i>   |                                  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br><i>#12 SAPPINGTON ACRES</i>  |  | Reside on Farm<br>No <input type="checkbox"/>   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <i>OTTO</i> Middle <i>A</i> Last <i>KNELL, SR.</i>  |                                  |   | 4. DATE OF DEATH<br>Month <i>JAN</i> Day <i>4</i> Year <i>1959</i>  |  |   |
| 5. SEX<br><i>MALE</i>   | 6. COLOR OR RACE<br><i>WHITE</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>MARCH 11, 1889</i>   |  | 9. AGE (In years last birthday)<br><i>69</i>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>EXECUTIVE</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>FLOOR COVERING</i>  | 11. BIRTHPLACE (City and state or country)<br><i>ST. LOUIS, MO.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |
| 13a. FATHER'S NAME<br><i>DANIEL KNELL</i>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><i>CLARA HARTMAN</i>   |   | 14. NAME OF HUSBAND OR WIFE<br><i>FRIEDA</i>                               |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><i>FRIEDA KNELL #12 SAPPINGTON ACRES</i>       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer of Liver</i>   |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>9/24/58 to 1/4/59</i>                                      |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                  | DUE TO (b)  |   | DUE TO (c) <i>581.6</i>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input 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.)  |  |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.   |                                  |   |   |  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <i>10/20/58</i> to <i>1/4/59</i> and last saw him alive on <i>1/4/59</i><br>Death occurred at <i>2 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |  |   |
| 22a. SIGNATURE<br><i>Geo. Granata M.D.</i>  |                                  | (Degree or title)   |   | 22b. ADDRESS<br><i>5521 S. Bldg</i>  |   |
|   |                                  |   |   | 22c. DATE SIGNED<br><i>1/4/59</i>  |   |
| 23a. BURIAL (CREMATION, REMOVAL)<br><i>REMOVAL</i>  |                                  | 23b. DATE<br><i>1/7/1959</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>PARK LAWN CEMETERY</i>            |   |
|   |                                  |   |   | 23d. LOCATION (City, town, or county) (State)<br><i>ST. LOUIS CO., MO.</i> |   |
| 24. FUNERAL DIRECTOR<br><i>J L ZIEGENHEIN &amp; SONS</i>  |                                  |   | ADDRESS<br><i>7027 GRAVOIS</i>  |  | 25. DATE RECD. BY LOCAL REG.<br><i>JAN 6 59</i>   |
|   |                                  |   |   |  | 26. REGISTRAR'S SIGNATURE<br><i>J. Carl Smith M.D.</i>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Donald E. Berg* .....

Licensed Embalmer No. *4863* .....

P. O. Address *7127 K...*

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.