

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015258

STATE FILE NUMBER

2 3926

FILED MAY 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6216 WINONA</u>		Length of stay in lb	d. STREET ADDRESS <u>6216 WINONA</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>F</u> Last <u>KNOLL</u>			4. DATE OF DEATH Month <u>APR.</u> Day <u>20,</u> Year <u>1959</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/89</u>	9. AGE (In years) <u>69</u> (Birth day)	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>JOHN MALSI</u>	13b. MOTHER'S MAIDEN NAME <u>FRIEDA MALSH</u>	14. NAME OF HUSBAND OR WIFE <u>HERMAN W KNOLL</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HERMAN F KNOLL</u> Address <u>6216 WINONA</u>
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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>ACUTE PULMONARY EDEMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</u>	<u>15 YRS.</u>
	DUE TO (c) <u>CORONARY INFARCTION</u>	<u>13 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.1</u>		19. WAS AUTOPSY PERFORMED? 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.) <u>420.1</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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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
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21. I attended the deceased from DEC, 1946 to APRIL, 1959 and last saw ^{her} him alive on APRIL 20, 1959
Death occurred at 7:55 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph R. Mackey M.D.</u>	22b. ADDRESS <u>745 Missouri Theatre Bldg</u>	22c. DATE SIGNED <u>4-21-59</u>
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23a. BURIAL, CREMATION, REMAINS (Specify) <u>CREMATION</u>	23b. DATE <u>4/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CREMATORY</u>	23d. LOCATION (City, town, or country) (State) <u>ST LOUIS COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>J L ZIEGENHEIN & SONS</u> ADDRESS <u>7027 GRAVOIS</u>	25. DATE RECD. BY LOCAL REG. <u>APR 21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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M. G. B.

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. Berry*
Licensed Embalmer No. *4963*
P. O. Address *St. Louis, 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.