

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023091

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ STATE FILE NUMBER Registrar No. 5814

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-57
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071
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
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 St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gatesworth Hotel		Length of stay in lb. 2 1/2 Mon.	d. STREET ADDRESS (If outside, give location) 4639 Penrose Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Henrietta Knecht			4. DATE OF DEATH Month Day Year June 17, 1959		
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5. SEX F.	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 March 6, 1883	9. AGE (In years last birthday) 76	10. FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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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) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Henry B. Keitz	13b. MOTHER'S MAIDEN NAME Rose Schulte	14. NAME OF HUSBAND OR WIFE Mr. Otto Knecht
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Albert A. Keitz, 3829 Lafayette Ave.	Address
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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) <i>Carcinoma, left breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 yrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>(Widespread metastases)</i> DUE TO (c) <i>170x</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Arteriosclerotic heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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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
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21. I attended the deceased from Death occurred at <i>June 9, 1959 6:50 am.</i>	<i>June 17, 1959</i> and last saw her alive on <i>June 16, 1959</i> m of the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Burke Eck M.D.</i> (Degree or title)	22b. ADDRESS <i>950 Francis Pl.</i>	22c. DATE SIGNED <i>June 18 '59</i>
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23a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>	23b. DATE <i>June 20, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, Missouri</i>
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24. FUNERAL DIRECTOR <i>Arthur J. Donnelly</i> ADDRESS <i>10 Lindell Blvd.</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 18 '59</i>	26. REGISTRAR'S SIGNATURE <i>Mr. Earl Smith, M.D.</i>
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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 

Licensed Embalmer No. 4699

P. O. Address 3840 Lemick

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.