

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027575

FILED VS AUG 10 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2090 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hgts</u>		c. CITY OR TOWN <u>St Johns</u>	
Length of stay in 1b <u>3 wks</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys</u>		d. STREET ADDRESS (If outside, give location) <u>3426 Lindscott</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Ann</u> Last <u>Knobbe</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/1909</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>		11. BIRTHPLACE (City and state or country) <u>Florissant Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Bernard Knobbe</u>		13b. MOTHER'S MAIDEN NAME <u>Elixabeth Birkemeler</u>	
14. NAME OF HUSBAND OR WIFE <u> </u>		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>495-30-9762</u>	
17. INFORMANT <u>Bernard Knobbe</u>		Address <u>3426 Lindscott</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>Adenocarcinoma of the Brain metastatic 2 Mo.</u>		DUE TO (b) <u>Adenocarcinoma of the left breast 1957</u>		DUE TO (c) <u> </u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Carcinomatosis</u>			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u> </u>			

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		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 7-26-59 to 8-2-59 and last saw her on 8-2-59
Death occurred at 3:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. Steiner MD</u>		22b. ADDRESS <u>3720 Washington Blvd</u>		22c. DATE SIGNED <u>8/4/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/5/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City, town, or county) (State) <u>Florissant Mo</u>	

24. FUNERAL DIRECTOR <u>Ortmann F Home</u>		ADDRESS <u>9222 Lackland Overland Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-4-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	
---	--	---	--	---	--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Sam Stepanov, Student Embalmer No. 57

working under my personal supervision.

Student

Sam Stepanov
Signature of Student Embalmer

Signed

Al C Ortman

Licensed Embalmer No. 3478

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.