

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032685

FILED VS SEP 22 1959

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 404 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>INDEPENDENCE</u>		c. CITY OR TOWN <u>INDEPENDENCE</u>	
Length of stay in 1b <u>40 yrs</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>1232 DICKINSON RD.</u>		d. STREET ADDRESS (If outside, give location) <u>1232 DICKINSON RD.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN HENRY KNAPHEIDE</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 12 59</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH.</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>JAN-28-1881 - 78</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>WARREN, CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>FREDICK. W KNAPHEIDE</u>		13b. MOTHER'S MAIDEN NAME <u>MATI'LOA SCHNEIDER</u>		14. NAME OF HUSBAND OR WIFE <u>LOLA KNAPHEIDE</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>491-20-0318</u>		17. INFORMANT Address <u>Lola Knapheide 1232 Dickin</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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Hugh O Owens Corcoran</u>		22b. ADDRESS <u>1034 Pulte Plaza</u>		22c. DATE SIGNED <u>9-14-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9/15/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bushner 500</u>	23d. LOCATION (City, town, or county) (State) <u>Bushner Mo</u>	
24. FUNERAL DIRECTOR <u>Reppert</u>	ADDRESS <u>Bushner mo</u>	25. DATE RECD. BY LOCAL REC. <u>9-14-59</u>	26. REGISTRAR'S SIGNATURE <u>James Craig</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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles E. Mayfield

Licensed Embalmer No. 463

P. O. Address Blue Springs

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.