# URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 26 1959 042

59-035269
STATE FILE NUMBER

ENDED

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1063

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Length of stay in 1b: 15 Yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2529 South 11th St. — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2529 South 11th — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ELSIE Middle A. Last KNAPP
4. DATE OF DEATH: Month October Day 20, Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Jan. 26, 04
9. AGE (last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Mound City, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Joe Elder
13b. MOTHER'S MAIDEN NAME: Arlina Graves
14. NAME OF HUSBAND OR WIFE: Roy R. Knapp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Roy R. Knapp Address: 2529 So. 11th City

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1957, to 10-20-59 and last saw her/him alive on [redacted] 10-20-59
Death occurred at 5:00 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clement C. DuMont M.D. (Degree or title)
22b. ADDRESS St. Joseph Mo
22c. DATE SIGNED 10-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 22, 1959
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Joseph, Mo.

24. FUNERAL DIRECTOR: H. O. Siebenfaden & Son — ADDRESS: St Joseph, Mo.
25. DATE RECD. BY LOCAL REG.: Oct. 21, 1959
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

RRY. 203

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF C.C. DuMONT, M.D. MEDICAL CERTIFICATION

**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 _____ Signed Robert H Yager

Signature of Student Embalmer

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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