

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013623

FILED VS MAR 30 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 904

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> | | Length of stay in lb <u>2 wks</u> | | c. CITY OR TOWN <u>Creve Coeur</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 Hosp</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>11718 Old Ballas</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>THEODORE</u> Middle <u>J</u> Last <u>KNEIP</u> | | | | 4. DATE OF DEATH Month <u>Mar</u> Day <u>16</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</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>11/29/90</u> | 9. AGE (last birthday) <u>69</u> | IF UNDER 1 YEAR Months <u> </u> Days <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>retired Hauler</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (City and state or country) <u>St. Paul, Minn.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>Joseph Kneip</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Maurer</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Nora Kneip</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW1</u> | | | 16. SOCIAL SECURITY NO. <u>477-03-2968</u> | | 17. INFORMANT <u>Nora Kneip 11718 Old Ballas</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>Cancer metastasis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Primary Adeno carcinoma</u> | | | | | | | |
| DUE TO (c) <u>of Colon</u> | | | | | | | |
| 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 <u> </u> a.m. <u> </u> p.m. <u> </u> | Month <u> </u> Day <u> </u> Year <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 <u>Feb 1960</u> to <u>March 16, 1960</u> . Last saw <u>her</u> alive on <u>3-15-60</u> . Death occurred at <u>2:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Martin G. Ouster MD</u> | | | | 22b. ADDRESS <u>634 W Grand Blvd</u> | | 22c. DATE SIGNED <u>3-16-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>3/16/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u> | | 23d. LOCATION (City, town, or county) <u>St Paul Minn.</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>Ortmann F Home 9222 Lackland Overland Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>3-16-60</u> | | 26. REGISTRAR'S SIGNATURE <u>John B. 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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al O. Ostrmann

Licensed Embalmer No. 3478

P. O. Address _____

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.