

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**LED VS MAY 17 1960**

**-60-020531**

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 7

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RRI O'Fallon Mo</u>	Length of stay in 1b <u>1 year</u>	c. CITY OR TOWN <u>RRI O'Fallon</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Rd. Nand Boonslick</u>		d. STREET ADDRESS (If outside, give location) <u>State Road Nand Boonslick</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Attillia</u> Middle <u>Knoll</u> Last <u>Knoll</u>			4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-1864</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Saint Charles, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>George Peters</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Made</u>		14. NAME OF HUSBAND OR WIFE <u>Charles B. Knoll</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>none</u>	17. INFORMANT <u>Mrs Joseph Cordes RRI O'Fallon Mo</u> Address			

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>Old Age</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 checked="" 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 9-23-57 to 5-10-60 and last saw him alive on 5-5-60  
 Death occurred at 6:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold G. Mungred D.O.</u>		22b. ADDRESS <u>O'Fallon, Mo</u>		22c. DATE SIGNED <u>May 12, 1960</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-15-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Catholic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>O'Fallon Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>O'Fallon Mortuary Inc. O'Fallon Mo</u> <u>Charles J Callahan</u>		25. DATE RECD. BY LOCAL REG. <u>5-13-1960</u>	26. REGISTRAR'S SIGNATURE <u>Ed Kertley</u>	

(Licensed Practitioner's Statement on Reverse Side)

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 J Callahan

Licensed Embalmer No. Permi

P. O. Address O'Fallon

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.