

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028524

Registration District No. **XC 16914267 318** Primary Registration District No. **SL 19484 1003** Registrar's No. **7193** STATE FILE NUMBER

FILED VS AUG 4 1960

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>	Length of stay in 1b <b>15 DAYS</b>	c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET ADM HOSPITAL</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5954 A WELLS</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>PETER J. KNIEST</b>			4. DATE OF DEATH Month Day Year <b>JULY 16, 1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-86</b>	9. AGE (last birthday) <b>73</b>	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) <b>STREET CAR OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>CHICAGO, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM KNIEST</b>		13b. MOTHER'S MAIDEN NAME <b>MARY BALM</b>		14. NAME OF HUSBAND OR WIFE <b>ANNA KNIEST</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES WWI</b>	16. SOCIAL SECURITY NO. <b>493-10-9050</b>	17. INFORMANT <b>ANNA KNIEST, 5954 A WELLS, ST. LOUIS, MO.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>STATUS POST OP BIFURCATION AORTIC GRAFT</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	
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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.) <b>456x</b>	
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. attended the deceased from **7-1-60** to **7-16-60** and last saw ~~her~~ him alive on **7-16-60**  
Death occurred at **12:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>RUSSELL M. PRESTON</b>	22b. ADDRESS <b>M.D. VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>7/16/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR <b>J.W. Clark F.H.1125</b>	ADDRESS <b>hodiament Ave</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 19 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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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 Stanley F. Dyer

Licensed Embalmer No. 419

P.O. Address St. L.

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