

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS. SEP 7 1960

**-60-033150**  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2572

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>1 1/2 DAYS</b>	c. CITY OR TOWN <b>Ballwin</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>St. Joseph Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>155 Hillcrest Drive</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Joel</b> Middle <b>Wesley</b> Last <b>Knickmeyer, Jr.</b>			4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/60</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>1</b> Days <b>1 1/2</b>	IF UNDER 24 HR Hours <b>1 1/2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Kirkwood, Missouri</b>		
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Joel Wesley Knickmeyer</b>		13b. MOTHER'S MAIDEN NAME <b>Nancy Wallis</b>		
14. NAME OF HUSBAND OR WIFE <b>Mrs. Joel W. Knickmeyer</b>		Address <b>155 Hillcrest Dr. Ballwin, Mo.</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Joel W. Knickmeyer</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		<b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Congenital heart lesion, mitral</b>	<b>2 days</b>
	DUE TO (c) <b>Myeloid defect, operative procedures</b>	<b>2 days</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Part of repair Congenital prothrombotic T.E. failure</b>		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 <b>11:15</b> a.m. <b>p.m.</b> Month, Day, Year <b>8/27/60</b>			

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 <b>Ballwin</b>	COUNTY <b>Ballwin</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>8/27/60</b> to <b>8/29/60</b> and last saw her/him alive on <b>8/29/60</b> Death occurred at <b>11:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>James C. Vest M.D.</b> (Degree or title)		22b. ADDRESS <b>634 N. Grand</b>		22c. DATE SIGNED <b>9/30/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug 30th 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St Johns Cem</b>	23d. LOCATION (City, town, or county) <b>Mehlville Mo.</b>	
24. FUNERAL DIRECTOR <b>Fey Funeral Home, Mehlville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-30-60</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

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 \_\_\_\_\_  
*No EMBALMING.*  
*Gen. Paul H. J.*  
Licensed Embalmer No. \_\_\_\_\_

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.