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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>6 yrs.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>               |  | c. CITY OR TOWN <b>St. Louis</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>3511 S. 2nd St.</b>  |  |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Viola</b> Middle Last <b>Knapp</b>                          |                                  |   | 4. DATE OF DEATH<br>Month <b>12</b> Day <b>9</b> Year <b>60</b> |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-7-79</b>                               | 9. AGE (last birthday)<br><b>81</b>                      | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WIPER</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Mo.</b> |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |                                  | 13a. FATHER'S NAME<br><b>Geo. Hart</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Viola C. Little</b>      |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>John F. Knapp</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.                                  |   |
| 17. INFORMANT<br><b>KAY HEISEL</b>  |                                  | Address <b>4916 DELOR</b>   |   |  |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs.</b> |
| DUE TO (b) <b>420.0</b>   |  |   |
| DUE TO (c) <b>Generalized Arteriosclerosis</b>  |  | <b>6 yrs.</b>                                     |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Terminal Bilateral Bronchopneumonia</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <input type="checkbox"/> Unknown |  |
|---|--|--|--|

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|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour 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 **11-3-54** to **12-9-60** and last saw her/him alive on **12-9-60**  
Death occurred at **1:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                     |                                    |
|---|-------------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>John W. Beckmann, M.D.</b> | 22b. ADDRESS<br><b>5800 Arsenal</b> | 22c. DATE SIGNED<br><b>12/9/60</b> |
|---|-------------------------------------|------------------------------------|

|  |           |   |  |
|--|-----------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL DEC. 14 1960</b> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY<br><b>JEFFERSON BARRACKS</b> | 23d. LOCATION (City, town, or county) (State)<br><b>ST. LOUIS Mo</b> |
| 24. FUNERAL DIRECTOR<br><b>Thomas Kutes 2906 Grand</b>                   | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><b>DEC 10 1960</b>              | REGISTRAR'S SIGNATURE<br><b>Paul Smith, 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 340

P. O. Address 2906 Pr

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.