

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044630

FILED VS NOV 28 1960

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3347

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brentwood		Length of stay in 1b 6 Mos.	c. CITY OR TOWN University City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 8950 Manchester		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8653 West Kingsbury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Nelson Middle A. Last Knierim	4. DATE OF DEATH Month Nov. Day 16, Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/4/96	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman	10b. KIND OF BUSINESS OR INDUSTRY Kookon Barber Co, Cinn., Ohio	11. BIRTHPLACE (City and state or country) Cinn., Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME August Knierim	13b. MOTHER'S MAIDEN NAME Harriet Castillon	14. NAME OF HUSBAND OR WIFE Bernice M. Knierim
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#1	16. SOCIAL SECURITY NO. 492-09-6635H	17. INFORMANT Bernice Knierim, 8653 West Kingsbury
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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) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis		2 yrs
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 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **5-15-60** to **11-16-60** and last saw ^{her}him alive on **11-15-60**.
Death occurred at **7:35 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS Kirkwood, Mo.	22c. DATE SIGNED 11/7/60
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23a. BURIAL, CREMATION, RECOVERY, OR DISPOSITION RECOVERY	23b. DATE Nov. 21, 1960	23c. NAME OF CEMETERY OR CREMATORY Nat'l. Cem., J.B., Mo.	23d. LOCATION (City, town, or county) (State) St. Louis Co., MO.
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24. FUNERAL DIRECTOR Wacker-Helderle, 3634 Gravois.	25. DATE RECD. BY LOCAL REG. 11-17-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Plummer M. Bell

Licensed Embalmer No. 4375
P.O. Address St. Louis 23 Mo

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