SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3063 STATE FILE NUMBER 61-011123

AMENDED

FILED APR 14 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Macon
c. CITY OR TOWN: Decatur Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 440 N. Pine St. Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: CLARA Middle: WISE Last: KNORR
4. DATE OF DEATH: Month: MARCH Day: 30 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/2/1887
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Decatur, Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Henry B. Wise
13b. MOTHER'S MAIDEN NAME: Emma McCool
14. NAME OF HUSBAND OR WIFE: Fred C. Knorr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Fred C. Knorr, Address: Decatur, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RUPTURE OF BERRY ANEURYSM, LEFT INTERNAL CAROTID ARTERY — 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) CONGENITAL MALFORMATION OF BLOOD VESSEL
DUE TO (c) 330 X
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 MARCH 28, 1961, to MARCH 30, 1961 and last saw her/him alive on MARCH 30, 1961
Death occurred at 10:50 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. R. Vernillia, M. D. M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 3/31/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-30-61
23c. NAME OF CEMETERY OR CREMATORY: Fair Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Decatur, Ill.

24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc. ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: MAR 31 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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_____ Signed Harry E. Monroe

Signature of Student Embalmer

Licensed Embalmer No. 4495

P. O. Address St Louis, Mo

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.