SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=011996
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 625

FILED VS MAR 16 1961

DATE AMENDED 1/2

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Sappington — Length of stay in 1b: MONS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Gravois Rest Haven — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5627 Lisette — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: ANNA Middle: E Last: KNOLL
4. DATE OF DEATH: Month: March Day: 3 Year: 1961
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11/21/1879
9. AGE (last birthday): 81 — 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): cashier
10b. KIND OF BUSINESS OR INDUSTRY: drug store
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Bernard Knoll
13b. MOTHER'S MAIDEN NAME: Clara Stumpe
14. NAME OF HUSBAND OR WIFE: -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clara Knoll Address: 5627 Lisette

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): Acute Pulmonary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Pulmonary Fibrosis & Emphysema (non-specific) 525x — years?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
~~DUE TO (c)~~
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arterio Sclerotic - Cardio - Vascular Disease
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 ☐ — None
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 11-11-60, to 3-3-61 and last saw her/him alive on 3-2-61
Death occurred at 3-3-61 6:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Allen M. Dearney M.D.
22b. ADDRESS: 4308 Effeter
22c. DATE SIGNED: 3-3-61

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 3/6/1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: John L Ziegenhein & Sons ADDRESS: 7027 Gravois
25. DATE RECD. BY LOCAL REG.: 3-3-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ INSTEAD OF BY AFFIDAVIT OF DOCUMENT

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 Donald Berry

Licensed Embalmer No. 4863

P. O. Address St Louis Mo.

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