

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8131

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 4 yrs.
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp. 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) 3424 Indiana Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Carl (Charles) Knigge
 4. DATE OF DEATH Month Day Year 8-29-61
 5. SEX Male
 6. COLOR OR RACE White
 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH JAN 13, 1896
 9. AGE (last birthday) 65
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BAKER
 10b. KIND OF BUSINESS OR INDUSTRY _____
 11. BIRTHPLACE (City and state or country) Mo.
 12. CITIZEN OF WHAT COUNTRY U-S-A.

13a. FATHER'S NAME Carl KNIGGE
 13b. MOTHER'S MAIDEN NAME Ida BEISIKER
 14. NAME OF HUSBAND OR WIFE _____
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I
 16. SOCIAL SECURITY NO. NONE
 17. INFORMANT Address ANNA KNIGGE 3535th CHEROKEE ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Pulmonary edema
arteriosclerotic heart disease with failure
 DUE TO (b) Arteriosclerotic Heart Disease & Failure
 DUE TO (c) 420.0
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 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 2-19-57 to 8-29-61 and last saw her/him alive on 8-29-61
 Death occurred at 10:50 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John W. Beckman, M.D. 22b. ADDRESS 5800 Grand 22c. DATE SIGNED 8/30/61
 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE SEPT. 1, 1961 23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY 23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MO.
 24. GENERAL DIRECTOR ADDRESS Thomas Kates 2906 Gravois 25. DATE RECD. BY LOCAL REG. SEP 1 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.