

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013548

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 924

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 27 1962

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in 1b 2 wks.	c. CITY OR TOWN Berkeley Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8112 Zoe Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Edward J. Middle Knarr Last Knarr			4. DATE OF DEATH Month 3 Day 16 Year 1962			
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 2-6-95	9. AGE (last birthday) 67	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Custodian	10b. KIND OF BUSINESS OR INDUSTRY Custodian	11. BIRTHPLACE (City and state or country) Evansville, Ind.	12. CITIZEN OF WHAT COUNTRY U. S.
------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Adelle Knarr
--------------------------------------	---------------------------------------------	----------------------------------------------------

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	17. INFORMANT Harold J. Knarr, Florissant, Mo.	Address
------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Chemia		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Biliary nephrosis.	
	DUE TO (c) Laennec's cirrhosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic pyelonephritis	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
--------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
---------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 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 12-27-1961 to 3-16-1962 and last saw her/him alive on 3-16-1962 Death occurred at 9:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Albert H. Howe MD (Degree or title)	22b. ADDRESS 601 So. Brentwood Blvd.	22c. DATE SIGNED 3/17/62 (State)
--------------------------------------------------------------	------------------------------------------------	--------------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-20-62	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Jefferson Barracks.
------------------------------------------------------------	-----------------------------	----------------------------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 3-19-62	26. REGISTRAR'S SIGNATURE John C. Murphy MD
---------------------------------------------------------------------	---------	------------------------------------------------	-------------------------------------------------------

VS 300 Rev. 4/59

14002
24010

3

4 0

5 1

6

7 1

8 1

9 381.1

10

11

12 45-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Reinhold K. Lohrmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 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.