

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018106

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 566

STATE FILE NUMBER

VS 300  
Rev. 4/59

15117

25117

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94200

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122-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

**FILED MAY 28 1962**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
Length of stay in 1b <b>1 1/2 Yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Methodist Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1205 Corby St.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>A.</b> Last <b>KNEIB</b>			4. DATE OF DEATH Month <b>May</b> Day <b>16,</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1881</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (1 1/2) Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>	11. BIRTHPLACE (City and state or country) <b>Buchanan Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Kneib</b>		13b. MOTHER'S MAIDEN NAME <b>Mary McDonald</b>		14. NAME OF HUSBAND OR WIFE <b>Josephine A. Kneib</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Josephine A. Kneib 1205 Corby St. City</b>		

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) <b>Arteriosclerotic Heart Disease</b>		<b>5 yrs</b>
DUE TO (b) <b>Cardiac Failure</b>		
DUE TO (c) <b>Arteriosclerosis General</b>		<b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Branchial Asthma</b>		
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 type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.		

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 6-10-57 to 5-16-62 and last saw <sup>her</sup>him alive on 5-16-62  
Death occurred at 10:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>H. C. Senne</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>223 n 7th St. Joseph Mo</b>	22c. DATE SIGNED <b>5-17-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 19, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hurlingen, Mo.</b>
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24. FUNERAL DIRECTOR <b>H.O. Sidempkes &amp; Son</b> <b>R.P.H.</b>	ADDRESS <b>St Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>May 18, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Wm Clark Goodell</b>
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USE BLACK INK OR TYPEWRITER RIBBON

*Side of a case*

*Dr. Dennis*

**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 *Robert H. Gipe*  
Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.