

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0033641

DO NOT WRITE ON THIS STUB

AMENDED

FILED 24 64

Registration District No. 317

Primary Registration District No. 543

Registrar's No. 2127

STATE FILE NUMBER

VS 300
Rev. 4/59

1 4008

2 4008

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jennings</u>			Length of stay in 1b <u>5 years</u>		c. CITY OR TOWN <u>Jennings</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2463 Hallfer Drive</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2463 Hallfer Drive</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u>		First		Middle <u>KNEUSEL</u>		Last	
4. DATE OF DEATH <u>Aug. 13 1964</u>		Month		Day		Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1878</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Hillsboro, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Wilko Pooker</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Lindhorst</u>			14. NAME OF HUSBAND OR WIFE <u>Albert Kneusel (deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Clara Schmidt 2463 Hallfer Drive</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 <u>8-8-62</u> to <u>present</u> and last saw her ^{him} alive on <u>8-2-64</u> Death occurred at <u>7 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Dr. Maxwell M.D.</u>			(Degree or title)			22b. ADDRESS <u>4500 Olive St.</u>	
22c. DATE SIGNED <u>8/13/64</u>			(State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (motor)</u>		23b. DATE <u>8/15/1964</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) <u>Hillsboro MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>SUEDMEYER & SON'S 3934 N. 20th Street</u>			25. DATE RECD. BY LOCAL REG. <u>8-13-64</u>		26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

USE BLACK INK OR TYPEWRITER RIBBON

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APR 11 1934

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 Stanley A. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.