

No. 2
4-12-40
5-17-39
I X2315

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. LUKES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME MAX H. KNORPP 561
(b) If veteran, name war No.
(c) Social Security No. Unknown

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years
7. Birth date of deceased Nov. 16 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 8 28 hr. min.

9. Birthplace DeSoto Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Real Estate Business

11. Industry or business

MOTHER FATHER { 12. Name Wm. J. Knorpp
13. Birthplace Oakvale Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mamie Hacke
15. Birthplace Valley Mines Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mamie Knorpp
(b) Address DeSoto, Missouri
17. (a) Removal (b) Date thereof 8-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation DeSoto, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) AUG 14 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town DeSoto NR
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day Twelfth
year 1940 hour 11 minute 35 P.M.

21. I hereby certify that I attended the deceased from August Sixth, 1940, to August 12, 1940:
that I last saw him alive on August 12, 1940:
and that death occurred on the date and hour stated above.

Immediate cause of death Subdural hemorrhage with clot formation

Due to
Due to [Signature]
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Subdural hemorrhage with clot formation
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank Buncel Jr. (M. D. or other) M.D.
Address St. Lukes Hospital Date signed 8/12/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed J. G. Sullivan
Licensed Embalmer No. 1122
P. O. Address.....

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 this body is not embalmed, fact should be so stated above.