

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036142

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9455** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 11 1962

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DATE AMENDED
Rev. 4/59			
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90	SHOULD READ	Mary R. Knittel	10/24/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DATE AMENDED

10/24/62

SHOULD READ

Mary R. Knittel

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY			
		St. Louis		2 1/2 years	Missouri					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits	d. STREET ADDRESS (If outside, give location)			Reside on Farm		
1109 Hornsby				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	1109 Hornsby			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH				
			AGNES	C	FISCHER	Month	Day	Year		
						October	1	1962		
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR			
female	white		9/19/1881	81 years	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY				
housewife				St. Louis, Missouri		U. S. A.				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Joseph Henke			Mary R. Knittel			John J. Fischer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	17. INFORMANT Address					
No					John J. Fischer - 1109 Hornsby					
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)								Interval		
DUE TO (b)								Interval		
DUE TO (c)								Interval		
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.		
Cerebral vascular insufficiency								<input type="checkbox"/> Yes <input checked="" 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.)							
			4200							
20c. TIME OF INJURY		Hour	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 Oct 13 1954 to Oct 1 1962 and last saw her alive on Sept 19 1962										
Death occurred at 11:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title)					22b. ADDRESS			22c. DATE SIGNED		
H. H. Suesener, M.D.					206 Northland Mex Bldg			10-2-62		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)		(State)	
burial			Oct 4, 1962	Calvary Cemetery			St. Louis		Missouri	
24. FUNERAL DIRECTOR ADDRESS					25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			
BUCHHOLZ MORTUARY-5967 W. Florissant Ave					10-3-1962		Road Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Informant

**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 Ralph C. Lindner

Licensed Embalmer No. 4275

P. O. Address St. Louis, 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.

MISSOURI BOARD OF EMBALMERS  
1001 WEST BROADWAY  
ST. LOUIS, MISSOURI 63102  
PHONE 527-1111