

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1478

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Wellston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
6340 Hobart  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Wellston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6340 Hobart  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
year 1942 hour \_\_\_\_\_ minute 55 A.M.

21. I hereby certify that I attended the deceased from June 22 1942 to July 7 1942  
that I last saw her alive on July 7 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis  
Due to Chronic coronary a. disease years

Due to GVA  
Other conditions General anaemia  
(Include pregnancy within 3 months of death) 7 mo.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

18. (a) Signature of funeral director Albert H. Hoppe Inc.  
(b) Address 4700 Washington Ave.  
23. Signature Dr. Hussbaum (M. D. or other)  
Address 3651 Grandel St. Date signed 7-9-42

3. (a) PRINT FULL NAME Pauline A. Knox  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Thomas B. Knox  
6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased Feb. 19 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 4 18 hr. \_\_\_\_\_ min.

9. Birthplace Boonville, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Henry F. Machler  
13. Birthplace Unk. Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary La Rose  
15. Birthplace Perrville, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas B. Knox  
(b) Address 6340 Hobart  
17. (a) Burial (b) Date thereof 7/10/42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fredricktown, Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.  
(b) Address 4700 Washington Ave.  
19. (a) JUL 9 - 1942 (b) C. H. Mc Larson  
(Date received local registrar) (Registrar's signature)

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

96  
0  
6

MOTHER FATHER

707

**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..... *Wilford G. Burnley* .....  
Licensed Embalmer No. *42021* .....  
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 this body is not embalmed, fact should be so stated above.**