

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jackson  
Township Port Osage  
or  
Village Port Osage  
or  
City Port Osage (NO. 1) (St. 1) Ward

Registration District No. 396  
Primary Registration District No. 5552

File No. 31376  
Registered No. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Edgar Knaphide

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Mar 5, 1911</u> (Month) (Day) (Year)		
AGE <u>X</u> yrs. <u>5</u> mos. <u>3</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Aug 8, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 8, 1911, to Aug 8, 1911, that I last saw him alive on Aug 8, 1911, and that death occurred, on the date stated above, at 1:30 p.m.  
The CAUSE OF DEATH\* was as follows:

Cholera Infantum  
11911 104  
(Duration) X yrs. X mos. 7 ds.

Contributory X  
(SECONDARY) (Duration) X yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) John W. Robertson M. D.  
Sp. 1, 1911 (Address) Buckner, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

PLACE OF BURIAL OR REMOVAL Bone Hill, Mo DATE OF BURIAL Aug 9, 1911  
UNDERTAKER Chas. Henthon ADDRESS Buckner, Mo

PARENTS	NAME OF FATHER <u>Florenz Knaphide</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Warren Co., Mo</u>
	MAIDEN NAME OF MOTHER <u>Mathilde Brinne</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Wellington Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.  
(Informant) Florenz Knaphide  
(ADDRESS) Buckner, Mo.

Filed Sept. 8, 1911 N. D. Baumgardner  
REGISTRAR

**PLACE OF DEATH**

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. \_\_\_\_\_

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

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

NAME OF FATHER \_\_\_\_\_

BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_, REGISTRAR \_\_\_\_\_

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ (Address) \_\_\_\_\_ M. D.

\*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) \_\_\_\_\_ At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Where was disease contracted if not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_