JUN 30 1927

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

Do not use this space.

17350

**1. PLACE OF DEATH**

County: Vernon
Township: Washington
City: ~~Nevada~~ (No. ..... St. ..... Ward)

Registration District No. 875
Primary Registration District No. 6162

File No. .....
Registered No. 93

**2. FULL NAME** Sarah E. Knapp

(a) Residence. No. Vernon Co. St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 21 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: F
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: D.K.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1851

7. AGE: Years 76 | Months D.K. | Days | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: D.K.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): D.K.

PARENTS
10. NAME OF FATHER: D.K.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): D.K.
12. MAIDEN NAME OF MOTHER: D.K.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): D.K.

14. INFORMANT: Hosp. Records
(Address): Nevada, Mo.

15. FILED 6/4 1927 E. R. King, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 29 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1926, to May 29, 1927 that I last saw her alive on May 29, 1927 and that death occurred, on the date stated above, at 3:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
arterio sclerosis
97
84
910
D.K. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Psychosis
D.K. (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) S. L. Wykoff, M.D.
5/29/, 1927 (Address) Nevada, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Stotesbury, Mo.
DATE OF BURIAL: May 30, 1927

20. UNDERTAKER: Allen Hays, Nevada, Mo.
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.