SEP 28 1927

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

Do not use this space.

24109

1. PLACE OF DEATH
County Greene
Township S Campbell
City Springfield Mo (No. ..... St. ..... Ward)

Registration District No. 318
Primary Registration District No. 5440

File No. .....
Registered No. 528

2. FULL NAME Katherine N Knapp
(a) Residence. No. R F D 8 St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 6 yrs. 2 mos. 24 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 6 - 1921

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
6	2	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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) Mo

PARENTS

10. NAME OF FATHER L E Knapp
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ethel M Dorsman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT L E Knapp
(Address) R F D 8

15. FILED 8/31 1927 O C Horst MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 8:30 pm 1927

17. I HEREBY CERTIFY, That I attended deceased from 10 am Aug 30 1927, to 8 pm Aug 30, 1927 that I last saw her alive on present when dead, and that death occurred, on the date stated above, at 8:30 pm p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Malignant Diphtheria

10 (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) 10 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C B Elkins, M. D
, 19 (Address) 318 College St

*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 Rozelwood Cemetery
DATE OF BURIAL 9/1 1927

20. UNDERTAKER W. L. Stone
ADDRESS Walnut Market

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.