

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

Do not use this space.

9344

1. PLACE OF DEATH

County Jackson
Township Prarie
City (No. City)

Registration District No. 400
Primary Registration District No. 553 B

File No.
Registered No. 44
.....St.Ward)

2. FULL NAME William Knapp

(a) Residence. No. Jackson County Home St.Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

Male | white | single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-10-1859

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.

69 | 0 | 0

8. OCCUPATION OF DECEASED

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

(c) Name of employer unknown

9. BIRTHPLACE (CITY OR TOWN) unknown
(STATE OR COUNTRY) New York

10. NAME OF FATHER Sylvius Knapp

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) unknown

14. INFORMANT J. W. Hostetter
(Address) Little Blue mo

15. FILED 229 1928 W. M. Schick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-10-1928

17. I HEREBY CERTIFY That I attended deceased from Jan 1, 1928, to March 7, 1928, that I last saw him alive on March 7, 1928, and that death occurred, on the date stated above, at 6 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 900
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

19. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. W. Greese M. D.
15 (Address) Independence 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 | DATE OF BURIAL
K.C. Central Dental College, Mo 1928

20. UNDERTAKER | ADDRESS

The State Anatomical Board
707 Hill Secy

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.

1928

