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

Do not use this space.

26557

1. PLACE OF DEATH

County Buchanan. Registration District No. 86

Township Washington Primary Registration District No. 5127

City (No. County Infirmery. St. Ward)

File No.

Registered No. 59

2. FULL NAME Francis Joseph Knapp.

(a) Residence. No. 9th & Hickory St. 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): October 4, 1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
71	10	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Unknown
(STATE OR COUNTRY): -----

PARENTS

10. NAME OF FATHER: Killian Knapp

11. BIRTHPLACE OF FATHER (CITY OR TOWN): *****
(STATE OR COUNTRY): Germany

12. MAIDEN NAME OF MOTHER: Katherine Karch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): *******
(STATE OR COUNTRY): Germany

14. INFORMANT: Frank Knapp
(Address): 821 Hickory St.

15. FILED: Aug 30 1928 J. J. Bunstock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): August 29 1928

17. I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1928, to Aug 27, 1928, that I last saw him alive on Aug 27, 1928, and that death occurred, on the date stated above, at 7-30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epilepsy

85

162 (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Senile Dementia

(duration) 2 yrs. mos. ds.

48

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Don't know

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A E Holley, M. D

Aug. 30, 1928 (Address) 822 Edmond 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: Mt. Olivet Cemetery

DATE OF BURIAL: Aug. 31 1928

20. UNDERTAKER: H. O. Sidenfaden.

ADDRESS: 1802 Union St.

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

70-10-23 SEP 24 1926

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan — Registration District No. 86 — File No. 59

Township Washington — Primary Registration District No. 5127 — Registered No. 59

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Francis Joseph Knapp

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

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 4 - 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	10	25	

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

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

14. INFORMANT .....
(Address)

15. FILED Oct 9, 1928 J J Bausch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1928

17. I HEREBY CERTIFY, That I attended/deceased from ....., 19....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(SECONDARY)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied [illegible] PHYSICIANS should state CAUSE OF DEATH in plain [illegible] it may be properly [illegible] OCCUPATION is very important.

REGISTRATION [illegible] EIVE A [illegible] FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-24557