

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

Do not use this space.

3924

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 1704 N. 20<sup>th</sup> St)

File No. ....  
 Registered No. 536  
 St. .... Ward)

**2. FULL NAME**

Joseph F. Knox  
 (a) Residence No. 1704 N. 20<sup>th</sup> St St. 26 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nellie Knox</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 18-1869</u>		
7. AGE <u>59</u>	YEARS	MONTHS
		DAYS
		If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

St. Louis  
 (STATE OR COUNTRY) Mo

PARENTS	10. NAME OF FATHER <u>Thomas Knox</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>
	12. MAIDEN NAME OF MOTHER <u>Catherine Duff</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>

14. INFORMANT Nellie Knox  
 (Address) 1704 N. 20<sup>th</sup> St

15. FILED Jan 11 1929 W. C. Stankoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 10 1929  
 17. I HEREBY CERTIFY, That I attended deceased from Jan 9 to Jan 10 1929  
 that I last saw him alive on Jan 10 1929 and that death occurred, on the date stated above, at 11:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Apoplexy, cerebral hemorrhage

82H (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) W.D. (duration) yrs. mos. ds.

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

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Dr. B. Stuegel M. D.  
11 1929 (Address) 1401 Madison

\*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 CALVARY DATE OF BURIAL 1/12 1929

20. UNDERTAKER Cullman Bros ADDRESS 17104 GRAND

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

5-1-96

Dr. Striegel

19<sup>th</sup> & Madison St

Central 9688

9 to 10 am