

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

Do not use this space.

14456

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)..... St. Ward)

File No.
Registered No. **3809**.....
St. Ward)

2. FULL NAME

Walter Knapp
(a) Residence. No. **8224 Reilly**..... St. **1**..... 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **ay 4-1911**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 8 10

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

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **MO**

10. NAME OF FATHER **Walter Knapp**

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

12. MAIDEN NAME OF MOTHER **Leela Monahan**

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

14. INFORMANT **Leela Knapp**
(Address) **8224 Reilly**

15. FILED **APR 16 1930** **W. C. Starkey**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr 14** 19**30**

17. **No Physician in Attendance**
I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... **4:30 P.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:
Shock & Injuries, Fractured Skull, occurred when an auto he was riding in over-turned near (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) **Bushick, Mo.** (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTACTED **Accident**
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?..... (Signed)..... **John P. Hurley, M.D.**
4/15, 1930 (Address) **City Coroner**

*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 **Mount Olive** DATE OF BURIAL **4-17-1930**

20. UNDERTAKER **Southern** ADDRESS **6320 S. Grand Bl.**

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.

