

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

Do not use this space.

15977

1. PLACE OF DEATH

County Jackson Registration District No. 398 File No. _____
 Township Bliss Primary Registration District No. 5554 Registered No. 153
 City Independence (No. 8713, Winner Road) St. _____ Ward _____

2. FULL NAME

Sarah Jane Knoch
 (a) Residence. No. 8717 Winner Road 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 Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22, 1896

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 10 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (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) Canada

PARENTS

10. NAME OF FATHER John Partridge

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

12. MAIDEN NAME OF MOTHER Caroline P. Dale

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

14. INFORMANT Wm. G. Knoch

(Address) 8717 Winner

15. FILED 5-2-30 F. L. Cook

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 5 1930

17. 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 6:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ruptured Heart
9:50
9:20
97 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Hall M. D.

5-6-1930 (Address) Allegany 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 DATE OF BURIAL

Mt Washington May 7 1930

20. UNDERTAKER ADDRESS

J. H. Newcomer's Sons Rt 6

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.

JUN 25 1930

10/27/72

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jackson Registration District No. 398 File No.
 Township Beene Primary Registration District No. 3554 Registered No. 153
 City (Name) St. Ward

2. FULL NAME Sarah Jane Knock
 (a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

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)

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
ruptured heart
chronic myocarditis
M. Hall Bert & Cook
 (duration) yrs. mos. ds.

CONTRIBUTORY Arterio-Sclerosis
 (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

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.

14. INFORMANT (Address)

15. FILED 7/5 1930 F. L. Cook REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS 19

20. UNDERTAKER ADDRESS

REVISIONS
 N. E. Item of information 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. REV. THIS SHALL NOT RECEIVE A KEY FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15977