

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

Do not use this space.

~~21567~~
21567

1. PLACE OF DEATH *Saline*
 County.....
 Township *Slater*
 City..... (No. St. Ward)
 Registration District No. *799*
 Primary Registration District No. *4479*
 File No.
 Registered No. *38*

2. FULL NAME *Mrs. May Knowles*
 (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 *7* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*
 4. COLOR OR RACE *Wh*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Geo W. Knowles.*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *--1865*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
about 65 ✓ ✓ ✓

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *House wife*
 (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) *Don't know*

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 *Geo W. Knowles*
 (Address) *Slater Mo*

15. FILED *624, 1930* *W. M. Tuttle*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 22 1930*
 17. I HEREBY CERTIFY, That I attended deceased from *June 15 1930* to *June 22 1930* that I last saw her alive on *June 22 1930*, and that death occurred, on the date stated above, at *4:15* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular incompetency of Heart
925

(duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *400*
 (duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) *W. M. Tuttle* M. D.
 , 19 (Address) *Slater 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
Slater City Cemetery *6-25 1930*

20. UNDERTAKER ADDRESS
Hill Brothers *Slater*

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.

