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

Do not use this space.

24049

JUL 25 1930

1. PLACE OF DEATH
County St. Clair
Township Roscoe
City Fleming (No. ..... St. ..... Ward)

Registration District No. 766
Primary Registration District No. 6011

File No. .....
Registered No. .....

2. FULL NAME William Harrison Knapp
(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 39 yrs. 7 mos. 2 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): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary C. Knapp

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

7. AGE: Years 59 | Months 5 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Hammond
(STATE OR COUNTRY): Illinois

PARENTS
10. NAME OF FATHER: Ira Knapp
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Desota
(STATE OR COUNTRY): Missouri
12. MAIDEN NAME OF MOTHER: Louisa Knapp
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Terra Haute
(STATE OR COUNTRY): Indiana

14. INFORMANT: Mrs. W. H. Knapp
(Address)

15. FILED 7/3 1930 J. P. Lyrum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 2nd 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-5 1930, to 6-5 1930, that I last saw him alive on 6-5 1930, and that death occurred, on the date stated above, at 4:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Rectum (Had destroyed all surrounding tissues)
46 D (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 45 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? X
( ) DID AN OPERATION PRECEDE DEATH? No. DATE OF X
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Malignant Growth
(Signed) J. W. Richardson, M. D.
, 19 (Address) Tiffin 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: Pleasant Springs Mo
DATE OF BURIAL: 7/3 1930

20. UNDERTAKER: J. B. Goodrich
ADDRESS: Roscoe Mo

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.

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 St. Clair Registration District No. 766 File No.
Township Roscoe Primary Registration District No. 6011 Registered No.
City (No. St. Ward)

2. FULL NAME William Harrison 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: M
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) Jan. 21 1871

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
59	5	11	

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 9/5 1930 J. P. Grum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 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 ....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

...y item of information should be carefully ... AGE should be stated EXACT... PHYSICIANS sh... DEATH in plain terms, so that it may be ... classified. Exact statement of OCCUPATION is very ... S SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLE... AS PRESCRIBED BY LAW