

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

Do not use this space.

24936

2923

1. PLACE OF DEATH

County Jackson Registration District No. 390

Township Kear Primary Registration District No. 1092

City Kanopolis No. 2307 Hatash

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 2307 Hatash St. 11 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 M. 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 4, 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
73 4 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. At Home
(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) Kentucky

10. NAME OF FATHER Harvey Knoff

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

12. MAIDEN NAME OF MOTHER Sophya Knoff

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

14. INFORMANT Malinda Knoff

(Address) 2307 Hatash

15. FILED 7/3, 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-1-1931

17. I HEREBY CERTIFY That I attended deceased from 6-29 1931 to 6-29 1931 that I last saw him alive on 6-29-31 and that death occurred, on the date stated above, at 12:25 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chorea
92A
87B (duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Endocarditis, Chronic (duration) yrs. ? mos. ? ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) [Signature] M. D. 7/2, 1931 (Address) 1583 E 18-

*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 Highland Cem. DATE OF BURIAL 7/3 1931

20. UNDERTAKER Watkins Bros. Undert. ADDRESS 729 Lyden

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.

