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

Do not use this space.

1. PLACE OF DEATH
County Johnson
Township Washington
City Knob Noster (No. ..... St. ..... Ward)

Registration District No. 429
Primary Registration District No. 4256

File No. 49337
Registered No. .....

2. FULL NAME Walter Y. Knaus
(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.

3

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-16-1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	82	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Miller
(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) Johnson Co. Mo

PARENTS
10. NAME OF FATHER Jacob Knaus
11. BIRTHPLACE OF FATHER (CITY OR TOWN) X 31
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Prigmore
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) X
(STATE OR COUNTRY)

14. INFORMANT Mrs. David Logan
(Address) Knob Noster Mo.

15. FILED 12/3, 1932 J. A. Koch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 3 1932

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1932 to Dec 3, 1932 that I last saw him alive on Dec 3, 1932 and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
(1) Cerebral Hemorrhage.
191
93C
871A
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) (1) Chr myocarditis
(2) Chr nephritis
(duration) 4 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? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
(Signed) Geo. Grove, M. D.
, 19 (Address) Knob Noster 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
City Cem Knob Noster	Dec-4 1932
20. UNDERTAKER	ADDRESS
C. L. Saults	K. N. 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.