

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

34630  
Do not use this space.

Registered No. **3966**

1. PLACE OF DEATH **11/21/1938**

(a) County Jackson Registration District No. 399

(b) Township Jean Primary Registration District No. 1002

(c) City Kansas City (d) Street No. W C Gen Hosp St.

(e) Length of residence in city or town where death occurred  
 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Frank Knapp

(a) Residence, No. 514 1/2 Main St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

FATHER 13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Ricord, Clerk  
17. C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL Sanialia Mich 10-11-38

19. FUNERAL DIRECTOR (ADDRESS) 536 Compall

20. FILED Oct 11, 1938 M. M. Brown  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-6-1938

22. I HEREBY CERTIFY, That I attended deceased from 11-6-1937 to 10-6-1938

I last saw he alive on 10-6-1938 Death is said to have occurred on the date stated above, at 7:25 PM

The principal cause of death and related causes of importance were as follows:

Achondroplastic dwarfism  
Chronic pulmonary tuberculosis

Other contributory causes of importance: 23 A

Date of onset

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
 specify.....  
 (Signed) P. J. De Marco, M. D.  
 (Address) W C Gen Hosp

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state EXACTLY.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**