

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

Do not use this space.

24413

**1. PLACE OF DEATH**

County Lenny Registration District No. 347  
 Township North Lenny Primary Registration District No. 5489A  
 City..... (No.....) Ward.....

File No.....  
 Registered No. 43  
 St..... Ward.....

**2. FULL NAME**

Mrs Elizabeth A Knolis

(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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1 - 1853

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
76 5 26

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

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

PARENTS

10. NAME OF FATHER Daniel Jackson

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

12. MAIDEN NAME OF MOTHER Moran

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Baltimore, Md

14. INFORMANT Mrs. Hans Knolis  
 (Address) Clinton Mo.

15. FILED July 27 1929 Dr. E. C. Peeler  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-27 1929

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:  
suicide by drowning

165 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 169  
 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) E. Swalker M. D.  
7-27, 1929 (Address) Clinton 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 Clinton Mo DATE OF BURIAL July 28 1929

20. UNDERTAKER Spore & Son ADDRESS Clinton 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.

AUG 24 1929

Autopsy

