

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

Do not use this space.

25448

**1. PLACE OF DEATH**

County Reels

Registration District No. ....

Township .....

Primary Registration District No. ....

City Reels

(No. 2)

Hospital

File No. ....

Registered No. R 24

St. .... Ward) ....

**FULL NAME** Emma Elizabeth Knipker

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married  
(write the word)

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

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Jan 12 - 1879

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
50 6 11

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

**9. BIRTHPLACE** (CITY OR TOWN) Monteague Co  
(STATE OR COUNTRY)

**10. NAME OF FATHER** John Grebach

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

**12. MAIDEN NAME OF MOTHER** Barbara Hoffmann

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

**14. INFORMANT** Jacob Knipker  
(Address) Jaurastau Mo

**15. FILED** 7-31-29

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) 7-23 1929

**17. I HEREBY CERTIFY**, That I attended deceased from 7-22 1929, to 7-23 1929, that I last saw h. or alive on 7-23 1929, and that death occurred, on the date stated above, at 4 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Hysterosalpingo-oophorectomy  
Shock from above  
operation

**CONTRIBUTORY** Carcinoma of uterus  
(SECONDARY) (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED** NO

IF NOT AT PLACE OF DEATH? .....

**DID AN OPERATION PRECEDE DEATH?** yes DATE OF 7-22-29

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Dr. Dyson, M. D.

764 .199 (Address) Reels 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** Monteague Evangelical Cem DATE OF BURIAL 7/26 1929

**20. UNDERTAKER** Walleau & Friedmeyer ADDRESS California

K. 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.

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