

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

Do not use this space.

40386

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **003**  
City..... *St. Louis* (No. *1010*) of *Lafayette* St. .... Ward)

File No. ....  
Registered No. **12437**

**2. FULL NAME**

(a) Residence. No. *1017* of *Lafayette* St. *23* Ward.

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *abt 69 - - -*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Laborer* (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) *Hungary*

10. NAME OF FATHER *Mrs Barton*

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

12. MAIDEN NAME OF MOTHER *Octavia Unknown*

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

14. INFORMANT *John Barton* (Address) *307 E. Delaware*

15. L. S. 3125 *man 6 Stanseloff* Filed..... 19..... REGISTER

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 27 1926*

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Strangulated Hernia*  
CONTRIBUTORY (SECONDARY) *Hernia* (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF *1/18/27* WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *[Signature]* M. D. (Address) *Corcoran*

\*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 *St. Trinity Lutheran* DATE OF BURIAL *12-31 1926*

20. UMBERTAKER *Southern W. Co* ADDRESS *1315 S. Broadway*

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.

