

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

Do not use this space.

24217

1. PLACE OF DEATH

County St Louis
Township Carondelet
City (No. Mount St. Rose Hospital)

Registration District No. 1123
Primary Registration District No. 6248 F

File No. _____
Registered No. 248
St. _____ Ward

2. FULL NAME

Christine Barton
(a) Residence. No. Zinn & Hoffmeister Ave 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-29-1904

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>26</u>	<u>3</u>	<u>27</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Honour work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St Louis mo
(STATE OR COUNTRY)

10. NAME OF FATHER Joseph Knapp

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

12. MAIDEN NAME OF MOTHER Eliz. Ott

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

14. INFORMANT Joe Knapp
(Address) Zinn & Hoffmeister Ave

15. FILED 7-30-30 L. C. Coburn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-26 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-14 1929 to 7-26 1930 that I last saw h.a. alive on 7-26 1930, and that death occurred, on the date stated above, at 12:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Tuberculosis
23A
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31
(duration) _____ yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

21. WHAT TEST CONFIRMED DIAGNOSIS? Charles Walters M. D.

(Signed) 7-26 1930 (Address) 401 So Broadway

*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.

22. PLACE OF BURIAL, CREMATION, OR REMOVAL St Peter Pauls Cem DATE OF BURIAL 7-29 1930

23. URBERTAKER C Hoffmeister & Co ADDRESS 401 So 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.

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