

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

Do not use this space.

28205

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *4568* *Enright*)

File No.
Registered No. *8047*
St. Ward)

2. FULL NAME

(a) Residence No. *4568 Enright* St. *12* Ward.

(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 *Henry F. Roll*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 5th - 1848*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
82 X 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Louisville*
(STATE OR COUNTRY) *Ky*

10. NAME OF FATHER *John H. Barth*

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

12. MAIDEN NAME OF MOTHER *Elyzabeth Burkemayer*

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

14. INFORMANT *Mrs. Dorothy Sanham*
(Address) *4568 Enright*

15. AUG 11 1930 FILED *W. C. Strickley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 10 1930*

17. I HEREBY CERTIFY, That I attended deceased from *July 12*, 1930, to *Aug 10*, 1930, that I last saw her alive on *Aug 10*, 1930, and that death occurred, on the date stated above, at *4:20 pm*.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heat prostration
97
191
(duration) yrs. mos. *28* ds.

CONTRIBUTORY (SECONDARY) *arteriosclerosis*
(duration) *8* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRASTED

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? *NO* DATE OF.....
WAS THERE AN AUTOPSY? *NO*
WHAT TEST CONFIRMED DIAGNOSIS *Now*
(Signed) *M. D. Demings*, M. D.

Aug. 11 1930 (Address) *4101 Washington Blvd.*
*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 *National Cemetery* DATE OF BURIAL *Aug 12 1930*
Jellison Barracks

20. UNDERTAKER *C. R. Lupton* ADDRESS *4749 Olive St.*

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.

4101 Washington

Lindell 1485

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