

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

Do not use this space.

29320

1. PLACE OF DEATH
 County St. Louis Registration District No. 790
 Township Central Primary Registration District No. 6033
 City St. Louis (No. St. Louis County Hospital Ward)

2. FULL NAME Lois Barklage
 (a) Residence. No. Maryland Heights 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 30, 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	9		8	

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

9. BIRTHPLACE (CITY OR TOWN) Maryland Heights
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Henry Barklage, Jr.

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

12. MAIDEN NAME OF MOTHER Eva Willken

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

14. INFORMANT Henry Barklage, Jr.
 (Address) Robertson, Mo. - R. 1

15. FILED Aug 31 1931 W. W. Sullivan
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 7 1931

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 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis
1193
 _____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Whooping Cough
 _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED St. Louis County
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHICH TEST CONFIRMED DIAGNOSIS Medical History
 (Signed) John O. Connell M. D.
 _____ (Address) Care of St. Louis County

*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 Free Free Cem DATE OF BURIAL 8/8/31

20. UNDERTAKER Burman Bros and Co. ADDRESS 2504 Woodson Ct. Overland 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 29 1931

MISSOURI STATE BOARD OF HEALTH - THIS IS A PERMANENT RECORD

