

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

Do not use this space.

7773

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. **1735**
City *St. Louis* (No. *St. Anthony Hospital* Ward)

2. FULL NAME

Christine Buxton
(a) Residence. No. *206 East Plouence* 16 Ward. *St. Louis 00. Mo*
(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) *Married*
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF *John Buxton*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 20 1857*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day,hrs. ormin.
<i>70</i>	<i>1</i>	<i>26</i>		

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

9. BIRTHPLACE (CITY OR TOWN)..... *Germany*
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER *Mike Zweigart*
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... *Germany*
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Mat. Krum*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... *Germany*
(STATE OR COUNTRY)

14. INFORMANT..... *John Buxton*
(Address) *206 E. Plouence*

15. **FEB 20 1933**
FILED.....
Max C. Staveland
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 19 1933*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 19*33*, to *Feb 19*, 19*33* that I last saw him alive on *Feb 18*, 19*33*, and that death occurred, on the date stated above, at *12:00* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
59 Dilatation of Heart
950 Diabetes Mellitus
CONTRIBUTORY (SECONDARY) *Diabetes Mellitus*
(duration) *2* yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED *59*
IF NOT AT PLACE OF DEATH.....

6 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) *A. W. Peters* M. D.
Feb 20, 1933 (Address) *4145 S Grand*

*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..... DATE OF BURIAL.....
Cyber Hill Mo. *Feb 21-33*

20. UNDERTAKER..... ADDRESS.....
Fundlich Red Co *17819 Mich.*

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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Handwritten signature or initials