

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.

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

Do not use this space.

JUN 28 1935

17677

1. PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033
 City Normandy, Mo. (No. 6920 Lexington Ave.) St. _____ Ward _____

File No. _____
 Registered No. 131

2. FULL NAME Kathryn Gott.

(a) Residence, No. 6920 Lexington Ave., St. _____ 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) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. H.H. Gott
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 14, 1878.
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 5 26
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Emil Dosenbach

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Augusta Stroth kamp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Dr. H. H. Gott. (ADDRESS) 6920 Lexington Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. DATE May 13/35.

19. UNDERTAKER (ADDRESS) W. W. Clark. 1125 Hodiamont Ave.

20. FILED 15-10-1935 W. W. Baechmer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May, 10/35. 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 1920 to May 10, 1935
 I last saw h. et. alive on May 8, 1935 Death is said to have occurred on the date stated above, at 10 P. M.

The principal cause of death and related causes of importance were as follows:

Carcinoma of the Spleenic flexure of colon Date of onset _____

Other contributory causes of importance NO

Name of operation Laparotomy Date of Oct 1932
 What test confirmed diagnosis? Microscopy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. H. Barto, M. D.
 (Address) 6128 Easton Ave

61 1/2^a Easton Ave.
ma. 7510.