

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUL 9 1935

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

Do not use this space.

24533

1. PLACE OF DEATH

County..... Registration District No. **1003**
Township..... Primary Registration District No.....
City *St. Louis Mo* (No., *Sanitatorium* St. Ward)

File No.....
Registered No. **5917**

2. FULL NAME *Lena Barskdale*

(a) Residence, No. *3744 Page* St. *11* Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *5* yrs. *11* mos. *26* 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 *Alonzo Barskdale*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 14 1883*

7. AGE YEARS *51* MONTHS *11* DAYS *25* IF LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *housework*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *housework*
10. Date deceased last worked at this occupation (month and year) *Oct. 1 1933* 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) *St. Louis Missouri* (STATE OR COUNTRY)

MOTHER FATHER
13. NAME *Matt Hoffman*

14. BIRTHPLACE (CITY OR TOWN) *New York* (STATE OR COUNTRY)

15. MAIDEN NAME *Amelia Wilsbergers*

16. BIRTHPLACE (CITY OR TOWN) *St. Louis Missouri* (STATE OR COUNTRY)

17. INFORMANT *William T. Gaitler M.D.* (ADDRESS) *5300 Arsenal St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Nalhalla* DATE *July-17, 1935*

19. UNDERTAKER *A. St. M. Loughlin* (ADDRESS) *2301 Lafayette Ave*

20. FILED *10 1935* 19 *J. Bredbeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 9* 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *March 21* 19*35*, to *July 9* 19*35*

I last saw *her* alive on *July 9* 19*35*. Death is said

to have occurred on the date stated above, at *12:47 p.m.*

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

General Paralysis of the Insane - Lucie Date of onset *3/21/35*

Other contributory causes of importance: *Hypostatic Pneumonia* *3/20/35*
Bronchitis

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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? *Y.* n.....
If so, specify.....

(Signed) *William T. Gaitler*, M. D.
(Address) *5300 Arsenal St.*

JOHN W. ...

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