

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.

23163

*Dr. W. M. Jones*  
3400 Meramec St.

**1. PLACE OF DEATH**

County.....

Registration District No. **701**  
**1002**

File No. ....

Township.....

Primary Registration District No. ....

Registered No. **6634**

City *St. Louis* (No. **4015**)

*Nebraska Ave.*

St. .... Ward)

**2. FULL NAME**

*Joseph J. Betschart*

(a) Residence. No. **4015 Nebraska Ave., St. Louis**

**24** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*male*

**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**

*Mary A. Betschart*

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

*Feb 28 - 1846*

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>83</i>	<i>3</i>	<i>22</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *hairdresser*

(b) General nature of industry, business, or establishment in which employed (or employer) *retired*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) *Switzerland*

**10. NAME OF FATHER**

*John J. Betschart*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Switzerland*

**12. MAIDEN NAME OF MOTHER**

*Don't know*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Don't know*

**14.**

INFORMANT *C. J. Betschart*  
(Address) *3411 Kerckhoff St.*

**15.**

FILED *NOV 28 1929*  
*W. M. Jones*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**3** **16. DATE OF DEATH (MONTH, DAY AND YEAR)** *6/19*  
**6-19-29**

17. I HEREBY CERTIFY, That I attended deceased from *8-29*, 19*28*, to *6-19*, 19*29*  
that I last saw him alive on *6-18*, 19*29*, and that death occurred, on the date stated above, at *7-15 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic Interstitial Nephritis*

*Chronic Myocarditis: arterio-sclerosis*  
(CONTRIBUTORY) (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

*1229 W. Kerckhoff St.*  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical*

(Signed) *Walter M. Jones, M. D.*

, 19 (Address) *3400 Meramec*

\*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**

*St. Peter & Paul Parochial Church* *June 22 1929*

**20. UNDERTAKER** **ADDRESS**

*W. M. Jones 2813 Kerckhoff St.*

