

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

Do not use this space.

14175

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.....

Township.....

Primary Registration District No. **100B**

Registered No. **3507**

City **Louis** (No. **4058**) **Louis Ave** St. (Ward)

2. FULL NAME **Kate Roth**

(a) Residence. No. **4058** **Louis Ave**, **11** Ward.

(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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Buchan Roth</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct. 18-1864</i>		
7. AGE	YEARS <i>65</i>	MONTHS <i>5</i>
	DAYS <i>19</i>	IF LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER *Not known / Chippard*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *England*
12. MAIDEN NAME OF MOTHER *Not known*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

14. INFORMANT *Mr. Gladys Maclell*
(Address) *4058 1/2 Louis Ave*

15. FILED **APR -8 1930** *Max C. Standen* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 7 1930*

I HEREBY CERTIFY, That I attended deceased from *July 19*, 19*29*, that I last saw h..... alive on *April 7*, 19*30*, and that death occurred, on the date stated above, at *12:30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetes Mellitus
59
43C

CONTRIBUTORY (SECONDARY) *Chronic mya carditis* (duration) *6* yrs. - mos. - ds.

18. WHERE WAS DISEASE CONTRACTED (duration) *4* yrs. - mos. - ds.

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *W. G. Kenning* M. D.

Apr. 7, 1930 (Address) *4548 Harris St*

*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 *Oak Hill, Kirkwood Mo* DATE OF BURIAL *Apr 10 1930*

20. UNDERTAKER *Carlson L. Reed* ADDRESS *207 N. Grand*

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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