

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

22826

1. PLACE OF DEATH

County Jackson
Township KAW
City Kansas City (No. 816 West 45th)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2017
St. 2017 Ward _____

2. FULL NAME Mrs. Carolyn C. St. John

(a) Residence. No. 816 West 4th St. 1 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) Widowed
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Andrew St. John

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13, 1839

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
90	11	23	

8. OCCUPATION OF DECEASED 92A
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 121
(c) Name of employer 127K

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

10. NAME OF FATHER Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Claude St. John
(Address) 816 West 45, K. C. Mo.

15. FILED 7/8 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6th 1930

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to July 6, 1930 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 3:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
Right & Left (terminal)
Mitral Stenosis (chronic)
15 year standing (duration) 15 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) all blood disease
with stone (duration) 15 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? ye

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Arthur C. Knox, M. D.
7/6, 1930 (Address) 1108 Riatt St B

*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 Forest Hill DATE OF BURIAL 7/8 30

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS K. City Mo.

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.

