LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

37641

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 11054

City St Louis Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Tom Robinson

(a) Residence. No. Kinloch - Mo, St., 7 Ward. Kinloch - Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: negro.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8/4/1842

7. AGE: Years 81. Months 4. Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(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) Alabama.

PARENTS
10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) 7
12. MAIDEN NAME OF MOTHER Caroline Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED DEC 7 1923 Max C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/4. 1923.

17. I HEREBY CERTIFY, That I attended deceased from 12/2, 1923, to 12/4, 1923, that I last saw h..... alive on 12/4, 1923, and that death occurred, on the date stated above, at 6 35 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
97 Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Arterio Sclerosis
(duration) 2 yrs. 3 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 918
DID AN OPERATION PRECEDE DEATH? NO DATE OF .....
WAS THERE AN AUTOPSY? NO.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & hab.

(Signed) L. Comission, M.D.
12/4, 1923 (Address) City Hospital #2

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington Park
DATE OF BURIAL: 12-7- 1923

20. UNDERTAKER: W S Wade Und Co
ADDRESS: 4202 Finney

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED ..... , 19 ....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.