

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

Do not use this space.

18735

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis (No. City Hospital #2)..... St. Ward)

File No.....
 Registered No. : 4084
 St. Ward)

2. FULL NAME

(a) Residence. No. 2918 Morgan St., 28 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 40 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 68

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Nil 186
 (b) General nature of industry, business, or establishment in which employed (or employer) 10
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

10. NAME OF FATHER Charlie Robinson

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

12. MAIDEN NAME OF MOTHER Fannie Fragia

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

14. INFORMANT (Address) Opama J. Woodard
City Hospital #2

15. FILED 30 1927 md. C. Starkopf REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 23, 1927

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to April 23, 1927 that last saw him alive on April 23, 1927, and that death occurred, on the date stated above, at 10:20 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
 (duration) yrs. mos. da. 3

CONTRIBUTORY (SECONDARY) Fracture Neck of Right Femur
Face down (duration) yrs. mos. da. 17

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

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) J. J. Thomas, M.D.

7/25/27 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood DATE OF BURIAL 5/1 1927

20. UNDERTAKER C. W. Roberts ADDRESS Lucas 3085

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.

