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

Do not use this space.

16363

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo. (No. Barnes Hospital St. ..... Ward)

File No. ..... Registered No. 4247

2. FULL NAME Robert Elliott Black

(a) Residence. No. ..... St., 12 Ward. Elsberry Mo.
(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: 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~~

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25 - 1846

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
80	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ret. farmer 137

(b) General nature of industry, business, or establishment in which employed (or employer) Self. 93D 113

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Allegheny City
(STATE OR COUNTRY) Penn

PARENTS

10. NAME OF FATHER William Lockey Black

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

12. MAIDEN NAME OF MOTHER Margaret Elliott

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

14. INFORMANT Roscoe Black
(Address) Elsberry Mo.

15. FILED MAY -5 1927 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

5

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5 - 2 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 4 - 11, 1927, to 5 - 2, 1927 that I last saw him alive on 5 - 2, 1927, and that death occurred, on the date stated above, at 8 25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis acute
Dilitation of stomach, acute
Enlargement of Prostate

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

CONTRIBUTORY (SECONDARY) Emphysema, Senile

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

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) Louis C Barrette, M. D

, 19 (Address) Barnes Hospital

*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: Valhalla Cem.

DATE OF BURIAL: May 7 1927

20. UNDERTAKER: Alexander & Sons

ADDRESS: 6175 Delmar

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.

THIS IS A PERMANENT RECORD