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

Do not use this space.

File No. 16978

Registered No. 4941

791

100

1. PLACE OF DEATH

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

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

City St. Louis (No. 3400, S. Grand Blvd St. ..... Ward)

2. FULL NAME Dr. Robert A. Wear

(a) Residence. No. 3400 S. Grand Bl St., 16 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 28 1838

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	8	26	

8. OCCUPATION OF DECEASED

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

(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) Illinois

PARENTS

10. NAME OF FATHER David Wear

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

12. MAIDEN NAME OF MOTHER Rachel Smalley

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

14. INFORMANT R. B. Young
(Address) 1318 N. Grand Bl

15. FILED MAY 26, 1927 Mark C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1927

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1927, to May 24, 1927, that I last saw him alive on May 24, 1927, and that death occurred, on the date stated above, at 7 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

NOTA

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(duration) ..... yrs. ..... mos. 10 ds.

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

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) F. B. Barger, M. D.

May 25, 19 (Address) 3165 S. Grand

*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	DATE OF BURIAL
Woodburn Ills.	May 27 1927
20. UNDERTAKER	**ADDRESS**
Cullinane Bros	1710 N. Grand Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

Dr. Garcia
3165 S. Grand Ave