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

Do not use this space.

18366

1. PLACE OF DEATH
County Jackson
Township 7 Fan
City 7 F. C. Mo. (No. Santa R.R. Condo Mo. St. Ward)
Registration District No. 399
Primary Registration District No. 1002
File No.
Registered No. 2469

2. FULL NAME Robert White
(a) Residence. No. 115 Taylor Ave Webster Grove Mo Webster Grove 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 Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27, 1905
7. AGE Years 21 Months 11 Days 22 If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(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) Mozel Mo
PARENTS
10. NAME OF FATHER Lee. White
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mozel Mo.
12. MAIDEN NAME OF MOTHER Lena Goode
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Union Mo
14. INFORMANT Hazel Renfro
(Address) 115 Taylor Ave Webster Grove
15. FILED 6/17 1927 M. M. Crowe Mo Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14-27
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:
Accidental R.R. Transmission
207M
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (SECONDARY)
(duration) ....yrs. ....mos. ....ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Inspection
(Signed) [illegible], M. D
6/14/27, 19 (Address) Deputy Coroner
*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 Kirkwood Mo
DATE OF BURIAL 6/17 1927
20. UNDERTAKER J. A. K. Fichtin
ADDRESS Kl. 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.

THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. E. ... WRITING INK—THIS IS A PERMANENT RECORD.
CAUSE ... DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGI... SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County..... Registration District No..... File No. 18266

Township..... Primary Registration District No..... Registered No. 2469

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

2. FULL NAME Robert White

(a) Residence. No..... St., ... Ward. Webster Groves
(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 6/17, 1927 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-14 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1927, 19..... that I last saw h... alive on June 14, 1927, and that death occurred, on the date stated above at ..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Accidental R. R. Traumatism
No auto involved

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

CONTRIBUTORY (SECONDARY) 66

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

18. WHERE WAS DISEASE CONTRACTED 188
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) H. Turner, Deputy Coroner, M. D.
6/14/27 19 (Address) Deputy Coroner

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

5-183.66