

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

Do not use this space.

23290

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **17174**

City **St. Louis** (No. **820 N. Beaumont St.**)

(No. **820 N. Beaumont St.**)

St. Ward)

2. FULL NAME

Robert Rowan

(a) Residence. No. **820 N. Beaumont St.** St. **22** 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. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **Abt. 45**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Labourer**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Miss.**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **H. W. Fath**
(Address) **Coconino office**

15. FILED **max b staroff** 19 **1927**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7/31 1927**

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at **4-15-0** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
M.M.G. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **1290** (duration) yrs. mos. da.

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

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

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **H. W. Fath** M.D.
8/3 1927 (Address) **Deputy Coroner**

*State the DISEASE CAUSING DEATH, or in cases from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Lobbersfield** DATE OF BURIAL **aug 8 1927**

20. UNDERTAKER **Co States** ADDRESS **4107 Fruney**

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.

PERMANENT RECORD

