

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

Do not use this space.

36073

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85  
 Township St. Joseph Primary Registration District No. 1001  
 City State Hospital (No. 2) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 1317

**2. FULL NAME**

(a) Residence. No. Liberty, Mo. Ward. Liberty, 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. 3 da. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1875

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
52 | — | —

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

9. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER R.P. Robinson

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

12. MAIDEN NAME OF MOTHER Mary Childs

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

14. INFORMANT State Hosp. Record  
 (Address) \_\_\_\_\_

15. FILED DEC 23 1927 John G. W. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1927, to Dec 21 1927, that I last saw him alive on Dec 21 1927, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute dilatation of the heart  
84 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY Insanity  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED Insanity  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

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

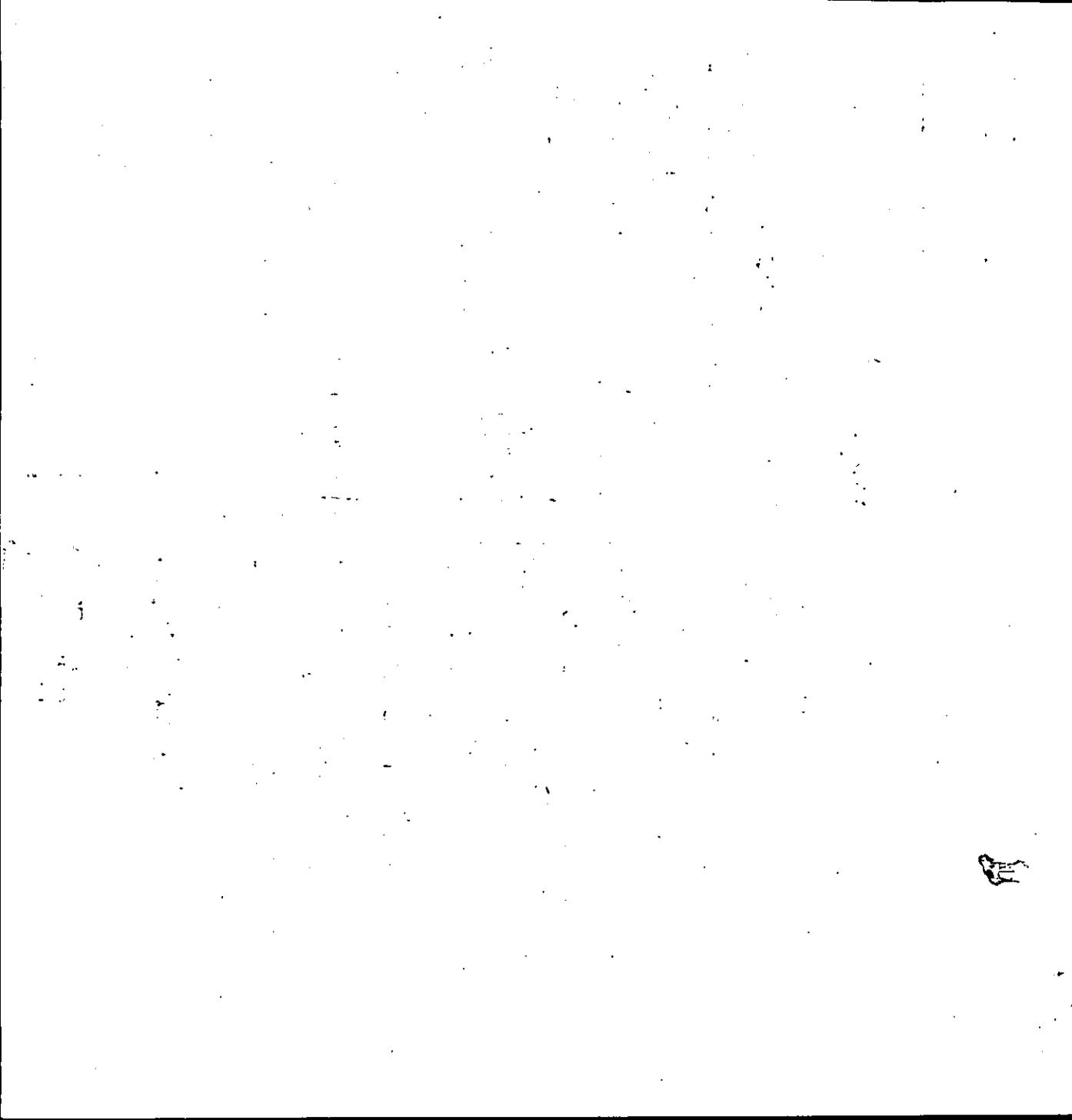
20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) Leland Galt, M. D.  
12/21 1927 (Address) St. Joseph, Mo.

\*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 Deaborn Mo DATE OF BURIAL 12/23 1927

20. UNDERTAKER Fleeman Funeral Home ADDRESS 1208 Main



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Buchanan  
Towaship St. Joseph  
City St. Joseph (No. \_\_\_\_\_)

Registration District No. 83  
Primary Registration District No. 1001

File No. \_\_\_\_\_  
Registered No. 1317  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Nellie Street

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF DEATH (MONTH, DAY AND YEAR) Unknown 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
52 Unknown

**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) \_\_\_\_\_

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. FILE 1/23, 1928 John G. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 1927

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:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) \_\_\_\_\_, M. D.  
, 19 (Address) \_\_\_\_\_

\*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 \_\_\_\_\_

20. UNDERTAKER ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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