

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

19055

791
1003

File No. _____
Registered No. **5472**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Precinct Registration District No. _____
City St. Louis (In _____ St. _____)

2. FULL NAME

George Benedict Robbers
(a) Residence. No. 345 Page Ave. Webster Ward. 12 Webster 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. 2 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 11 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Carlenton
(c) Name of employer Dry Goods Co

9. BIRTHPLACE (CITY OR TOWN) Duquoy
(STATE OR COUNTRY) Ill. U.S.

10. NAME OF FATHER John Robbers

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

12. MAIDEN NAME OF MOTHER Elizabeth Green

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

14. INFORMANT Lucille Robbers
(Address) 345 Page Ave

15. FILED 19 1928 May 21 1928
REGISTRAR Wm C. Starker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 18 1928
17.

I HEREBY CERTIFY, That I attended deceased from May 14, 1928, to May 18, 1928, that I last saw h. alive on May 17, 1928, and that death occurred, on the date stated above, at 3 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage from renal artery
153R (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis of renal vessel (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Anthony B. Day, M. D.
7/21, 1928 (Address) 3720 Washington Blvd.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Matthews DATE OF BURIAL May 21 1928

20. URBERTAKER Becker and Co Webster ADDRESS Graves

This certificate should be submitted to the health officer of the city or town in which the death occurred. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County
Towship *St. Louis*
City *St. Louis* (No.) St. Ward

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *5472*
St. Ward

2. FULL NAME

(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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *M*

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)

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 *Maple Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 18 1928*

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Hemiplegia from renal arteriosclerosis, cause unknown. Information given over phone by Dr. A. H. Key, M.D. 7-12-28. (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Arterio Sclerosis of renal vessel (duration) yrs. mos. ds.*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *916* DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Arthur B. Key, M.D.*, M. D.
, 19 (Address) *3720 Franklin*

*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

19

SUPPLEMENTARY

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

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language. Occupation should be properly classified. Exact statement of OCCUPATION is very important. REG. FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-19055