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

Do not use this space.

22215

File No. 6427

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. Christian Hospital St. Ward)

2. FULL NAME Robert Smith

(a) Residence. No. 2119a Gravois St., 23 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 XXXXXXXX

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 14, 1909

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	8	2	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Oregon co.
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Albert Smith

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

12. MAIDEN NAME OF MOTHER Frona Sherley

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

14. INFORMANT Mrs Frona Clayburgh.
(Address) 2119 a Gravois Ave

15. FILED JUN 18 1928 Helen C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 16 1928

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1928, to June 16, 1928 that I last saw h. alive on June 16, 1928 and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculor Meningeles

(duration) ..... yrs. ..... mos. 2 1 ds.

CONTRIBUTORY (SECONDARY) .....

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

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) C. H. Depp, M. D.

June 18 1928 (Address) Missouri Bldg

*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 Laurel Hill Cemetery

DATE OF BURIAL June 18 1928

20. UNDERTAKER A. W. McLaughlin

ADDRESS 1631 Missouri

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.

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