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

Do not use this space.

22749

1. PLACE OF DEATH
County Stoddard — Registration District No. 837
Township Castor — Primary Registration District No. 6099
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Robert Wilson
(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): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: D.K.
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Not Known
7. AGE: about 50 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Pauper
(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): Not Known

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: Alex Mooney
(Address): Old Mo. Sup. Co. Home
15. FILED 6-9, 1928 S. S. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6/3 1928
17. I HEREBY CERTIFY, That I attended deceased from May 24, 1928, to June 31, 1928 that I last saw him alive on June 32, 1928, and that death occurred, on the date stated above, at 6 o'clock m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronical Pneumonia
10 TA
1000 (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (SECONDARY): dont know
..... (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) A R Reynolds, M. D
, 19 (Address) Bloomfield 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: Co. Home
DATE OF BURIAL: 6-4 1928
20. UNDERTAKER: J. A. Childs
ADDRESS: Bloomfield

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.

JUL 10 1928