

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

Do not use this space.

38940

1. PLACE OF DEATH

County.....*Spous*.....Registration District No. *791*
Township.....*Spous*.....Primary Registration District No. *1003*
City.....*Spous* (No. *6915 So Broadway*).....St.Ward)

File No.
Registered No. *11415*.....
St.Ward)

2. FULL NAME

(a) Residence. No. *6915 So Broadway* St. *1* 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 <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>widow</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Mary Robinson</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Jan 26 1865</i>		
7. AGE <i>64</i> YEARS	<i>9</i> MONTHS	<i>24</i> DAYS
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>laborer retired</i> (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		
9. BIRTHPLACE (CITY OR TOWN)..... <i>Sh. Va</i> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <i>Es Robinson</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <i>Sh. Va</i> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <i>unknown Stark</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <i>Sh. Va</i> (STATE OR COUNTRY)	
14. INFORMANT..... <i>Mrs Oanda Bethune</i> (Address) <i>1095 Foxcroft Ave</i>		
15. FILED..... <i>21 1934</i> REGISTRAR <i>Wm O Starkoff</i>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-20-1929*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 8*, 19*29*, to *Nov 20*, 19*29*, that I last saw h. in alive on *11-15*, 19*29*, and that death occurred, on the date stated above, at *9:45 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Bright's disease (cause not known)

130 (duration) yrs. *3* mos. ds.

CONTRIBUTORY *Chronic rheumatoid arthritis* (SECONDARY) (duration) *1* yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *N. J. Salsbery*, M. D.
Nov 21, 1929 (Address) *3558 Lafayette*

*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 <i>Valhalla</i>	DATE OF BURIAL <i>11/23 1929</i>
20. UNDERTAKER <i>A Ellis 5210 Delmar</i>	ADDRESS

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

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.

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