

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

Do not use this space.

40621
B. 5026

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1002
 City W. C. Caring (No. General Hospital) St. _____ Ward _____

2. FULL NAME Robert Belcher
 (a) Residence. No. 3611 Mt Gal St. 16 Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-30-1895

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>34</u>	<u>33</u>	<u>0</u>	<u>6</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Printer
 (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) Mo.

10. NAME OF FATHER Oscar Belcher

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

12. MAIDEN NAME OF MOTHER Fanny Cochran

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

14. INFORMANT Miss Vera Belcher
 (Address) 3611 Mt Gal, av

15. FILED 12/7 19 29 W. W. Crowe REGISTRAR
ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-6-1929

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Homicide, fire arm
173

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

CONTRIBUTORY Shot by police officer
 (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 Autopsy
 (Signed) Stanley M. Hall M.D.

1929 (Address) Reputy Coroner

*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 Memorial Park DATE OF BURIAL Dec 7, 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS W. E. Mo.

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.

