

MAR 28 1930

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

Do not use this space.

6115

1. PLACE OF DEATH

County St. Charles
Township _____
City _____ (No. _____)

Registration District No. 757
Primary Registration District No. 2036

File No. _____
Registered No. 27
St. _____ Ward _____

2. FULL NAME Nettie Belle Robbins

(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.

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 15, 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas J. Robbins, Decd.

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1930 to Feb. 15, 1930, and that I last saw h. _____ alive on _____, 19____, and that death occurred; on the date stated above, at 4:30 P.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 19, 1851

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 4 26

Pneumonia - Influenzal
95B
11A
(duration) _____ yrs. _____ mos. 18 ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTORY (SECONDARY) Cardio-Renal disease
(duration) long yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) Hagerstown, Maryland
(STATE OR COUNTRY)

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

10. NAME OF FATHER Oliver Stonebraker

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Not known

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. J. Lewis, M. D.

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

, 19____ (Address) St. Charles, 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.

14. INFORMANT Edw. T. Robbins
(Address) 612 N. 6th St.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove Cem. DATE OF BURIAL Feb. 18, 1930

15. FILED 2/17, 1930 H. J. Blochman
REGISTRAR

20. UNDERTAKER Steinbinker Turn. Co ADDRESS St. Charles

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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