

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

Do not use this space.

7283

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis, Mo. (No.)

File No.

Registered No. 2170

St. Ward)

2. FULL NAME

Bernard Robinson

(a) Residence. No. 14 1/2 Gay st. St. 25 Ward.

(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 male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-1-1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>	<u>20</u>	

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Ivy Robinson

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

12. MAIDEN NAME OF MOTHER Sizzie Thompson

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

14. INFORMANT Ivy Robinson (Address) 14 1/2 Gay st.

15. FILED 144 19 11/11/30 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-21-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-18-1930 to 2-21-1930 that I last saw him alive on 2-21-1930 and that death occurred, on the date stated above, at 538 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
Primary
10 1/2 hrs
19 1/4 B (duration) yrs. mos. ds. 4
CONTRIBUTORY (SECONDARY) exposure (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF none

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) Dean William Johnson, M. D.
2-26-1939 (Address) 4039d Hinney

*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 Greenwood DATE OF BURIAL March 3-1930

20. UNDERTAKER A. S. Beal Und. Co. ADDRESS 2726
Suburban

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.

