

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

Do not use this space.

14510

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis, Mo. No. City Hospital # 2

File No.....
Registered No. 3857
St. Ward)

2. FULL NAME

Robert Minor
(a) Residence. No. 4403 Garfield St. 11 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 110 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>		4. COLOR OR RACE <u>Col.</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>8-29-1901</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.	
	<u>28</u>	<u>7</u>	<u>12</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>Chauffeur</u>					
(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) <u>Ala.</u>					
PARENTS	10. NAME OF FATHER <u>Unknown</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>				
	12. MAIDEN NAME OF MOTHER <u>Virginia Minor</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>				
14. INFORMANT <u>A. Cleopatra Creath</u> (Address) <u>City Hospital # 2</u>					
15. FILED <u>APR 17 1930</u> <u>May E. Harbly</u> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-11-1930

17. HEREBY CERTIFY, That I attended deceased from 4-5-1930 to 4-11-1930 that I last saw him alive on 4-11-1930 and that death occurred, on the date stated above, at 4:45 m. P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis
2 P.M.
(duration) - yrs. 3 mos. 21 ds.

CONTRIBUTORY (SECONDARY) SI
(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? NO

WHAT TEST CONFIRMED DIAGNOSIS X-Ray + Sputum
(Signed) A.E. Haley M. D.

*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 Father Dickson Cem DATE OF BURIAL April 20 1930

20. UNDERTAKER A.L. Beal and Co ADDRESS 2926 Lucas

WRITE PLAINLY, 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.

