

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791  
1003**

File No.....

Township.....

Primary Registration District No.....

Registered No.....

City.....

St..... Ward)

**2. FULL NAME**

(a) Residence. No. 13019 Outglr St., 16 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 Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-24-30

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Mil  
(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 Pester Robinson

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

12. MAIDEN NAME OF MOTHER Juanita Moore

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

14. INFORMANT A Gertrude Greath  
(Address) City Hospital #2

15. FILED 12 1930 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-2-1930

17. I HEREBY CERTIFY, That I attended deceased from 5/24, 1930, to 6/2, 1930 that I last saw h alive on 6/2, 1930 and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Intoxication  
119 B  
154 (duration) - yrs. - mos. - ds.

CONTRIBUTORY (SECONDARY) Acute Gastro Enteritis  
(duration) - yrs. - mos. - ds.

18. WHERE WAS DISEASE CONTRACTED 113 B  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) A. C. Hale M. D.

6/11 . 19 30 (Address) City Hosp. #2  
\*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 POTTERS FIELD. DATE OF BURIAL 6-19-1930

20. UNDERTAKER Long Astor 2945 Fulton ADDRESS

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.

20870 ~~20088~~

