

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

Do not use this space.

24597

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. City Hospital #2
(No. City Hospital #2)

File No.....
Registered No. 6755
St..... Ward.....

2. FULL NAME

Thos Robinson
(a) Residence No. 3912 Euclid St. Ward. 11

Length of residence in city or town where death occurred 10 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 Male
4. COLOR OR RACE Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>About 44</u>	<u>-</u>	<u>-</u>	<u>-</u>	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. C.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT A. Glorinda Crutch
(Address) City Hospital #2

15. JUL 12 1930
FILED 19 W. C. Walker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-5 19 30

17. I HEREBY CERTIFY, That I attended deceased from 6-13 1930 to 7-5 1930, that I last saw him alive on 7-5 1930, and that death occurred, on the date stated above, at 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of mesenteric glands
4 1/2 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 45 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
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) W. H. Sleath M. D.

77 19 30 (Address) City Hospital #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 Washington Park Cem DATE OF BURIAL 7-13-30

20. UNDERTAKER Peoples Und. Co. ADDRESS Franklin

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

