

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

Do not use this space.

28012

File No. _____
Registered No. **7841** St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis mo.** (No. **City Hospital**)

2. FULL NAME *William Robbins*

(a) Residence. No. **Dalman & Russell St.** **23** Ward. _____
(Usual place of abode) **1708 E Russell** (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 **male**
4. COLOR OR RACE **white**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **unknown**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **about 1859**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **about 71 - -**
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) **soft drinks Porter**
(c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-5 1930**
17. **No Physician in Attendance**
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at **2:20 A.M.**
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Fractured Skull
Struck by Auto
St. Louis Mo. mos. ds. _____
CONTRIBUTORY (SECONDARY) **Accident** (duration) yrs. mos. ds. _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) **Germany**
10. NAME OF FATHER **unknown**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Germany**

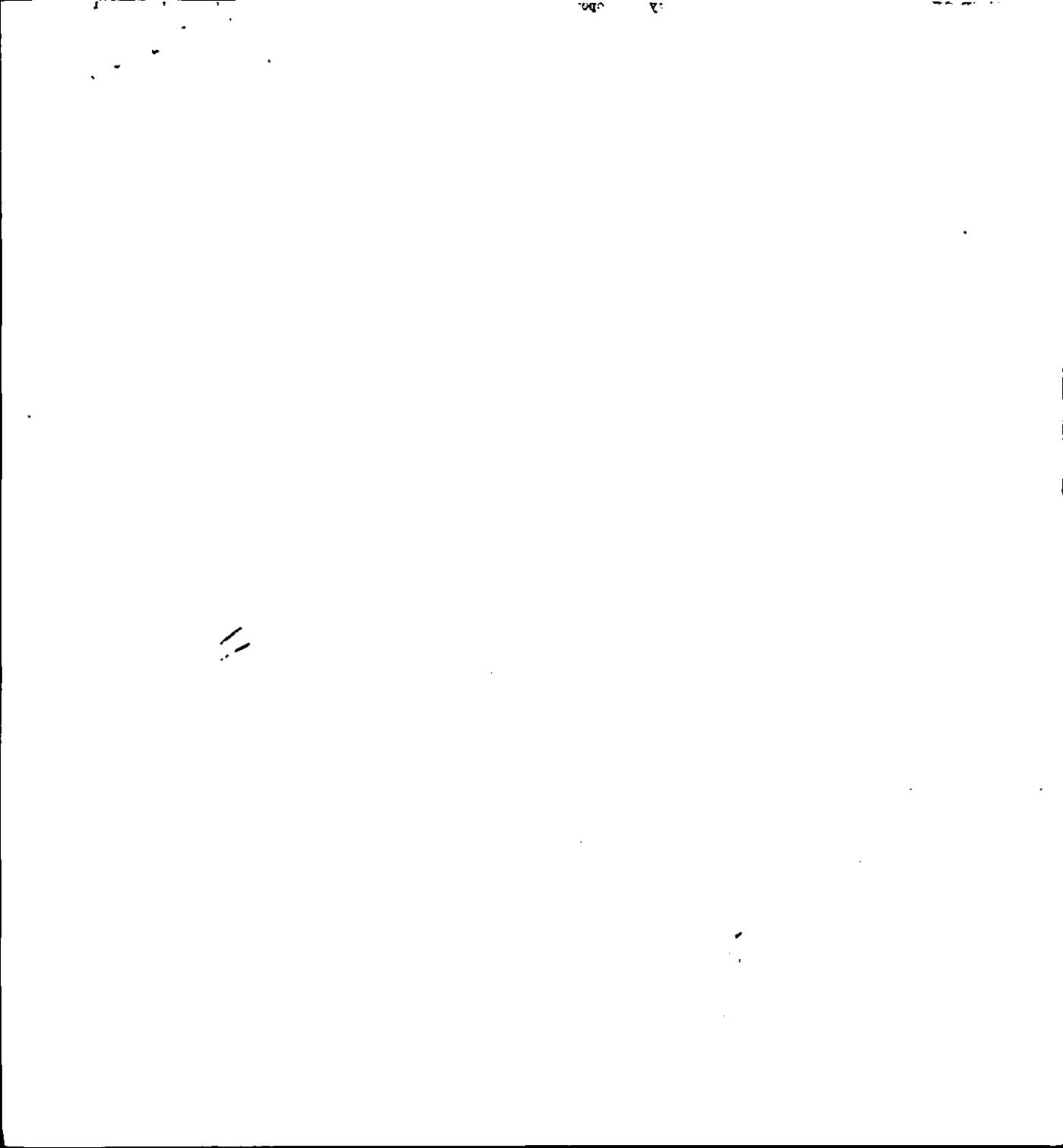
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
8 DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? **yes**
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. W. Ferraro, M.D.**
8/6, 1930 (Address) **Dep. Coroner**
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT **Mrs. M. Nickerson**
(Address) **1117 N. North Park Pl.**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **S. S. Peters & Pauls** DATE OF BURIAL **8-7 1930**
20. UNDERTAKER **M^cLaughlin** ADDRESS **1631 mo av.**

15. FILED **6 1930** **May C. V. ...** REGISTRAR

Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. so that it may be properly classified.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 7841
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME William 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-5 1930

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Shock & injuries fractured skull struck by auto

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 _____

CONTRIBUTORY (SECONDARY) accident on highway to street

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

1880 WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

(Signed) _____, M. D.
 _____, 19 _____ (Address) _____

*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 _____ (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILED 1930 Mar. C. Stahlhoff REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-28012