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

Do not use this space.

37555

1. PLACE OF DEATH

County..... Registration District No. 7011 1003

Township..... Primary Registration District No.....

City St. Louis (No. Deaconess Hospt. St. ..... Ward)

File No..... Registered No. 10634

2. FULL NAME Robert W. Claridge

(a) Residence. No..... St., 4 Ward. Maryland Hgts. Mo.
(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

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 6 1930.

7. AGE: Years ..... Months 3 Days 2 If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Maryland Hgts Mo.

PARENTS

10. NAME OF FATHER: Sylvester Claridge

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Winfield Mo.

12. MAIDEN NAME OF MOTHER: Loretta Maxwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Valley Park Mo.

14. INFORMANT: Sylvester Claridge
(Address) Maryland Heights Mo.

15. FILED: Nov 9 1930, 19.. Mary C. Farley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 6th, 1930, to Nov 7th, 1930 that I last saw h. alive on Nov 7th, 19.., and that death occurred, on the date stated above, at 10:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anhydremia (Acidosis)
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): Otitis media purulent acute ? (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? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. H. Kohlsing, M. D
11/8, 1930 (Address) 3720 Washington St.

*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: Fee Fee Cemetery — DATE OF BURIAL: Nov 10 1930

20. UNDERTAKER: Bunmann Co. — ADDRESS: Maryland Mo.

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