

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

Do not use this space.

30022

1. PLACE OF DEATH

County St Louis
Township St Louis
City St Louis

Registration District No. 185
Primary Registration District No. 1005

File No.
Registered No. 9086
St. Ward)

2. FULL NAME

(a) Residence No. 4411 McPherson 19 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 35 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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 10 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chemist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer R W Hunt Co

9. BIRTHPLACE (CITY OR TOWN) Malone
(STATE OR COUNTRY) New York

10. NAME OF FATHER Chas. F. Robertson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Peekskill
(STATE OR COUNTRY) N.Y.

12. MAIDEN NAME OF MOTHER Rebecca Deane

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

14. INFORMANT Chas C. Robertson
(Address) 841 Belt St

15. FILED AUG 26 1931 MM C. Stander REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-25 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1931, to Aug 25, 1931, that I last saw him alive on Aug 25, 1931, and that death occurred, on the date stated above, at 11:10 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute dilatation heart
93C
95B

CONTRIBUTORY (SECONDARY) myocarditis chronic
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination

(Signed) E. U. Master, M. D.

8/25, 1931 (Address) 908 Beaumont Bldg

*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

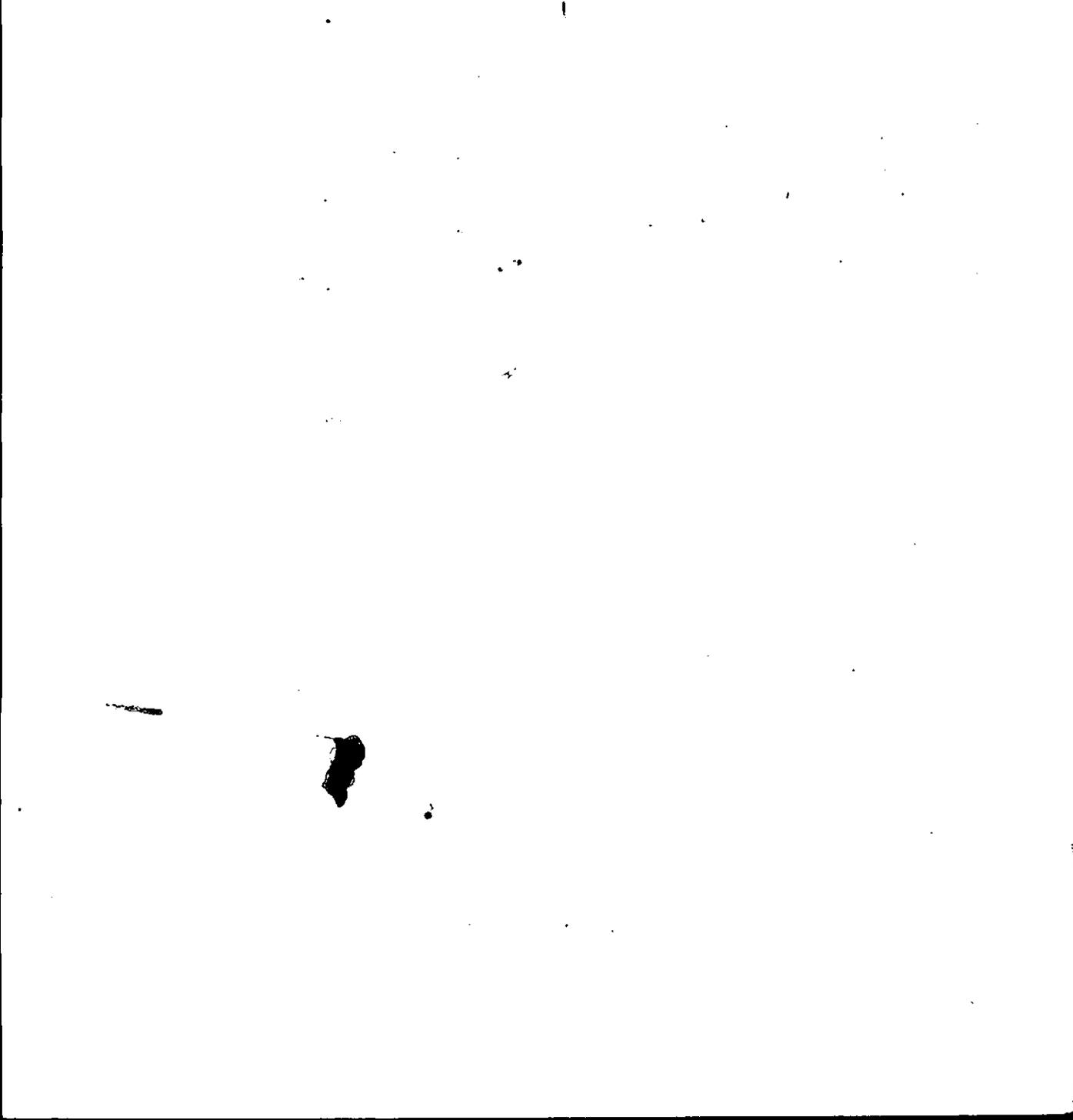
DATE OF BURIAL

Bellfontaine 8-28 1931

20. UNDERTAKER

ADDRESS

Alexander & Sons 6175 P. St.



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

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. 1013 Registered No. 9086
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 14 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>X</u>	<u>63</u>	<u>X</u> <u>11</u>	<u>11</u>	

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 _____

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

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 101-3 Sept 14 1903 Wm C. Fardley REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/25 1931

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(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.

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

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE

SUPPLEMENTARY

5-30022