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

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.

NOV 10 1933

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

Do not use this space.

1. PLACE OF DEATH
County: St Louis — Registration District No. 1170 — File No. 34425
Township: Central — Primary Registration District No. 6248 H — Registered No. 242
City: Richmond Hts (No. St. Mary's Hospital, St. ..... Ward)

2. FULL NAME: Fannie D. Robb
(a) Residence, No. 5678 Cabanne St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
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: White
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): Jan 27 - 1855

7. AGE — YEARS: 77 — MONTHS: 9 — DAYS: # — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: At Home
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Jacksonville Ill

FATHER
13. NAME: David Robb
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pa.

MOTHER
15. MAIDEN NAME: Catherine Reed
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Alexandria Virginia

17. INFORMANT: Clara B. Post
(ADDRESS) 5678 Cabanne

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Jacksonville Ill DATE: Oct 30, 1933

19. UNDERTAKER: C. R. Lupton & Sons
(ADDRESS) 4449 Olive St

20. FILED: OCT 30 1933, 19 ..... Gertrude Porter, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Oct 27th 1933

22. I HEREBY CERTIFY, That I attended deceased from August 22nd, 1933, to October 27th, 1933
I last saw her alive on October 27th, 1933. Death is said to have occurred on the date stated above, at 10 15 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Cardiac Delatation	10/27/33
Other contributory causes of importance:	
Carcinoma of Pylorus and of Stomach	8/22/33

Name of operation ..... Date of ..... What test confirmed diagnosis? Clinically Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) August G. Heilmann, M. D.
(Address) 6194 Delmar Blvd

Dr. A. S. Wilchmann
6194 Delmar
Pa. 1407

1-3 P.m.
7-21 Greenway
Pa. 0293