

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 25 1934

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

Do not use this space.

10907

1. PLACE OF DEATH

County \_\_\_\_\_ Registration District No. **701**  
Township \_\_\_\_\_ Primary Registration District No. **1003**  
City St. Louis (No. Carleton Hosp)

File No. \_\_\_\_\_  
Registered No. **2757**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Robert Fleming  
(a) Residence, No. 2738 N. Wheaton St. N.R. Ward \_\_\_\_\_  
(Usual place of abode) St. Louis Co. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 4 1/2 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 \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 27, 1926  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
8 1 19

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Harrison School  
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) St. Louis County

MOTHER FATHER  
13. NAME Arthur J. Kline

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

MOTHER FATHER  
15. MAIDEN NAME Lillie Berg

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Grace Barr  
5622 Woodland St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE March 21 1934

19. UNDERTAKER (ADDRESS) Benzick Niehaus  
1138 N. 7th

FILED MAR 15 1934  
J. Baedek Registrar.

7 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 18 1934  
22. I HEREBY CERTIFY, THAT I attended deceased from Mar 14 1934, to Mar 18 1934  
I last saw him alive on Mar 18 1934 Death is said to have occurred on the date stated above, at 6:30 p.m.  
The principal cause of death and related causes of importance were as follows:

Measles Date of onset \_\_\_\_\_  
Brounchopneumonia  
Septicæmia, Sepsis  
Other contributory causes of importance:  
Cerebral Abscess  
Staphylococci, Related  
Meningitis, Acute  
Name of operation Tracheotomy Date of \_\_\_\_\_ 1934  
What test confirmed diagnosis? Cerebral Was there an autopsy? No

23. If death was due to external cause (violence), fill in also the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
Where did injury occur? No  
(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?  
If so, specify No  
(Signed) John E. Claiborne M. D.  
Address ISOLATION HOSPITAL

