

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.

13 1934

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

Do not use this space.

37292

1. PLACE OF DEATH

County: St. Louis Registration District No. 791  
Township: \_\_\_\_\_ Primary Registration District No. 1003  
City: St. Louis, 505 Kingshighway (No. St. Louis Childrens Hospital Ward)

File No. 9689

Registered No. \_\_\_\_\_

2. FULL NAME

Robert E. Carlisle  
(a) Residence, No. Box 164 St. NR Ward. Oreton, Texas  
(Usual place of abode) (If nonresident, give city of town and State)  
Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-26-33

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>9</u>	<u>7</u>		

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. Child  
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) Texas

MOTHER FATHER 13. NAME Reverend Carlisle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ala.

15. MAIDEN NAME Gladys Griffing

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

17. INFORMANT J. Mc Swin (ADDRESS) 505 S. Kingshighway

18. BURIAL, CREMATION, OR REMOVAL PLACE Christy's Mass DATE 10/3/34

19. UNDERTAKER Devauden Long (ADDRESS) 6175 Kingshighway

20. FILED 111-3-107A 19 34 J. Brebeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-3-34

22. I HEREBY CERTIFY, That I attended deceased from 9-26-34, 1934, to 10-3-34, 1934.  
I last saw h. i. m. alive on 10-3-34, 1934. Death is said to have occurred on the date stated above, at 12:24 a. m.  
The principal cause of death and related causes of importance were as follows:

Broncho pneumonia  
107A  
107A  
Other contributory causes of importance: Congenital alactaria

Date of onset 9-29-34

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1934

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) Julia L. Adams, M. D.  
(Address) 500 S. Kingshighway

