

MAY 29 1935

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

Do not use this space.

13398

1. PLACE OF DEATH

County *Lafayette*
Township *10th*
City *St. Louis*

Registration District No. *464*
Primary Registration District No. *5622A*

File No. *1731*
Registered No. *21*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St., _____ Ward, _____
(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

Robert Samuel Colvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m.* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Clashy Fels Colvin*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 15, 1853*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
81 3 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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) *Virginia*

13. NAME *James W. Colvin*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*

15. MAIDEN NAME *Mary Ann Shank*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Botetown, Virginia*

17. INFORMANT *J. W. Colvin* (ADDRESS) *Odessa Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Sumner Cem* DATE *April 15/15* 1935

19. UNDERTAKER *F. C. Schubman* (ADDRESS) *Odessa Mo.*

20. FILED *5-10-* 1935 *Mrs. E. M. Goodwin* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 13* 1935

22. I HEREBY CERTIFY, That I attended deceased from *March 14* 1935, to *April 11* 1935

I last saw him alive on *April 11* 1935. Death is said to have occurred on the date stated above, at *11 A.* m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (Lobar) Date of onset *April 6*

Other contributory causes of importance: *about two months ago the patient had a poplexy. The throat was affected posth.*

Name of operation *none* Date of _____

What test confirmed diagnosis? _____ 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) *E. P. Bean D.O.* * *

(Address) *Odessa 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.

