

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.

JAN 13 1936

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

Do not use this space.

41370

1. PLACE OF DEATH

County ..... Registration District No. 791  
Township ..... Primary Registration District No. 1008  
City St. Louis (No. 2909 University)

File No. ....  
Registered No. 10591  
St. .... Ward)

2. FULL NAME William C. Robinson

(a) Residence, No. 2909 University St. 20 Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Delia</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 18, 1870</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>9</u>
		DAYS <u>27</u>
	If LESS than 1 day, ..... hrs. or ..... min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Lumber Inspector</u>	
	9. Industry or business in which work was done, as mill, saw mill, bank, etc. <u>Hardwood Lumber</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 15, 1935  
22. I HEREBY CERTIFY, That I attended deceased from Dec 10 <sup>9</sup> 35 to Dec 15 <sup>15</sup> 1935  
I last saw him alive on Dec 15, 1935 Death is said to have occurred on the date stated above, at 12:45 p.m.

The principal cause of death and related causes of importance were as follows:  
Cerebral Pneumonia Date of onset

Other contributory causes of importance: 108

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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?  
If so, specify  
(Signed) W. C. [Signature] M. D.  
(Address) 2206 Howard St.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

FATHER

13. NAME Jacob Robinson

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

MOTHER

15. MAIDEN NAME Frances Harris

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

17. INFORMANT Mrs. Delia Robinson  
(ADDRESS) 2909 University

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Not Hope DATE 12/17, 1935

19. UNDERTAKER Ashton & Co.  
(ADDRESS) 2707 N. Grand Blvd.

20. FILED C 16 1935  
J. T. Bredeck  
Registrar.

