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

Do not use this space.

26902

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 3515

City K.C. Mo (No. General Hospital #2 St. Ward)

2. FULL NAME Robinson Fannie

(a) Residence. No. 1805 Grove St., 4 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: colored
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) Mar 25 1927

7. AGE: 3 YEARS (14) MONTHS 4 (22) DAYS 23 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Fredrick Robinson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill
12. MAIDEN NAME OF MOTHER: Lena Payne
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Lena Robinson
(Address) 1805 Grove St. K.C. Mo

15. FILED 8/25, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-17-30 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930 to Aug 1930 that I last saw her alive on Aug 17, 1930, and that death occurred, on the date stated above, at 11 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
T.B. Meningitis
24A
unknown (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 22A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH unknown

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Cerebrospinal fluid tested

(Signed) [illegible]
Dr. D. M. Moore Gen Hosp #2
(Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: West Lawn Cemetery — DATE OF BURIAL: Aug 26 1930

20. UNDERTAKER: West, Appleton & Jones — ADDRESS: K.C. 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.