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

Do not use this space.

31775

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 3640, Marine Ave., St. ..... Ward)

File No. .....

Registered No. 9456

2. FULL NAME Robert Daily

(a) Residence. No. 809 N. Grand Ave., St., 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Colored	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt.	40	?	?	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. duties of

(c) Name of employer Janitor, firing furnace, etc.

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

PARENTS

10. NAME OF FATHER Aaron Daily

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT [signature]
(Address) 3640 Marine Ave., St. Louis, Mo.

15. FILED [illegible] 19 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 29, 1930 19

17. I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1930, 19..., to Sept. 29, 1930 19..., that I last saw him alive on Sept. 29, 1930, 19..., and that death occurred, on the date stated above, at 8:55 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic paranchymatous nephritis 131

Chronic myocarditis 93C

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 129A

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Edmund R. Sheridan M. D.

9-29-30 19 (Address) 3640 Marine Ave., St. Louis, Mo

*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	DATE OF BURIAL
Charlesville - Miss	10/4 1930
20. UNDERTAKER	**ADDRESS**
Hoffmeister U & L Co	7814 So Bdwy