

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.

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

Do not use this space.

38355

DEC 3 1936

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Marion Primary Registration District No. 3029
 City Hannibal (No. Leveering Hospital) St. _____ Ward _____

File No. _____
 Registered No. 266

2. FULL NAME Robert Thomas White

(a) Residence, No. 1510 E St St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

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 Male 4. COLOR OR RACE White 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) June 19, 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 4 T

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. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Hannibal (STATE OR COUNTRY) Mo

FATHER 13. NAME Arthur T. White

FATHER 14. BIRTHPLACE (CITY OR TOWN) Louisiana (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Minnie Selan

MOTHER 16. BIRTHPLACE (CITY OR TOWN) Hannibal (STATE OR COUNTRY) Mo

17. INFORMANT Mr Arthur T. White (ADDRESS) 1510 E St. Hannibal, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Not Observed DATE Oct. 20, 1936

19. UNDERTAKER James O. Daniel (ADDRESS) Hannibal, Mo

20. FILED Oct 20 1936 H. C. Fisher Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 18, 1936

22. I HEREBY CERTIFY, That I attended deceased from September 28, 1936, to October 18, 1936

I last saw him alive on October 18, 1936 Death is said to have occurred on the date stated above, at 9:45 a.m.

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

Bacillary Dysentery Date of onset 9/20/36

Other contributory causes of importance:
Numerous abscesses of the skin
Toxic Encephalitis
 Name of operation Blood Transfusions Date of _____
 What test confirmed diagnosis? 0 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?
 If so, specify _____
 (Signed) Samuel B. Landon, M. D.
 (Address) Hannibal, Missouri

