

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

Do not use this space.

**26921**

**1. PLACE OF DEATH**

County Gasconade  
Township Clay  
City                      (No.                     )

Registration District No. 302  
Primary Registration District No. 6231

File No.                       
Registered No.                       
St.                      Ward                     

**2. FULL NAME**

Alma Larene Robison

(a) Residence. No.                      St.                      Ward                       
(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 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)                     

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 4 17

**B. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work                       
(b) General nature of industry, business, or establishment in which employed (or employer)                       
(c) Name of employer                     

9. BIRTHPLACE (CITY OR TOWN) Gasconade, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Sam Robison

11. BIRTHPLACE OF FATHER (CITY OR TOWN) State, MO.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lizg Pasch

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Overmull, Mo  
(STATE OR COUNTRY)

14. INFORMANT Sam Robison  
(Address) Gasconade, Mo

15. FILED Sept 18 1927 W. Bunge REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 7 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6 1927, to Sept. 7 1927, that I last saw her alive on Sept. 6 1927, and that death occurred, on the date stated above, at 6:00 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septicemia  
13C  
78B (duration) yrs. mos. ds.  
CONTRIBUTORY Inflammatory condition  
(SECONDARY) at base of brain (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home  
IF NOT AT PLACE OF DEATH?

DID IN OPERATION PRECEDE DEATH? NO DATE OF                     

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Objective symptoms

(Signed) J. J. Ferrell, M. D.  
9-7-1927 (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 Overmull, Mo DATE OF BURIAL 9-8-1927

20. UNDERTAKER Humberg ADDRESS Overmull

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Do not use this space.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Gasconade Registration District No. 309 File No. ....  
Township Clay Primary Registration District No. 6231 Registered No. ....  
City ..... (No. ....) St. .... Ward .....

**2. FULL NAME**

Alma Lorene Robison

(a) Residence. No. .... 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 F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1 - 1927

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

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work  
(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)

**PARENTS**  
10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED Sept 18 1927 Ed Brunge REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19..... that I last saw h. .... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

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

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.  
, 19 (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

18198-2