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

Do not use this space.

FEB 27 1934

File No. 5493

Registered No. 8

1. PLACE OF DEATH

County Laclede — Registration District No. 448

Township Huron — Primary Registration District No. 5608

City Phillipsburg (No. ....., ... St. ..... Ward)

2. FULL NAME John Robinson

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown Mrs. Robinson - other name "

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
About 77				

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

9. BIRTHPLACE (CITY OR TOWN) ~~[illegible]~~
(STATE OR COUNTRY) Indiana

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not known

14. INFORMANT Ed O'Quinn, Supt Co. Farm
(Address) Phillipsburg

15. FILED 2-[illegible] 1934 Ora Montgomery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-3- 1934

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1931, to Feb. 3, 1934 that I last saw ~~him~~ alive on Feb. 3 1934, and that death occurred, on the date stated above, at 5-30- P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Entro-Colitis
120B
(duration) 2.0 yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH on farm in Sec.
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical only
(Signed) E. Taylor, M. D.
, 19 (Address) Phillipsburg, 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
Phillipsburg Cem.	2-4 1934
20. UNDERTAKER	**ADDRESS**
J. H. Moffat	Conway 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD