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.

LSD JUN 19 1939

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

18204
Do not use this space.

1. PLACE OF DEATH
(a) County: Callaway — Registration District No.: 104
(b) Township or (c) City: Fulton — Primary Registration District No.: 3008 — Registered No.: 151
(d) Street No.: State Hosp #1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred: 1 yrs. 9 mos. 9 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Rube Robinson
(a) Residence, No.: Moberly Mo., St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: C
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): Jan ? 1860

7. AGE: Years 79 — Months 4 — Days ? — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Laborer
9. Industry or business in which work was done, as 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) (STATE OR COUNTRY): Howard Co Mo

FATHER
13. NAME: Reuben Robinson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky

MOTHER
15. MAIDEN NAME: Angeline Robinson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

17. INFORMANT (ADDRESS): State Hosp #1 Records Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Columbia Mo DATE: 6-3, 1939

19. FUNERAL DIRECTOR (NAME): J. O. Roberts
(ADDRESS): Columbia Mo

20. FILED: June 5, 1939 — C. N. Crews, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 5/30, 1939

22. I HEREBY CERTIFY, That I attended deceased from 5/25, 1939, to 5/30, 1939
I last saw h. l. alive on 5/30, 1939. Death is said to have occurred on the date stated above, at 10:17 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Syphilis	34

Other contributory causes of importance: Syphilitic Meningo Encephalitis, Dehydration, Malnutrition

Name of operation: Date of:
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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? No
If so, specify:
(Signed): Geo. T. Wood, M. D.
(Address): State Hosp #1 Fulton Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.