

REC'D JUN 21 1939

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

19027  
Do not use this space.

1. PLACE OF DEATH  
(a) County Laclede Registration District No. 499  
(b) Township Lebanon Primary Registration District No. 5609  
(c) City ..... (d) Street No. ....  
(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME 152 Leranzy Dew Robinson  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Zola Pauline Robinson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 15 1908  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
31 0 13  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Mechanic  
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) Laclede Co Mo  
13. NAME Henry W Robinson  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo  
15. MAIDEN NAME Effie Henderson  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co. Mo.  
17. INFORMANT (ADDRESS) Zola Pauline Robinson

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/27/39 19  
22. I HEREBY CERTIFY, That I attended deceased from 4-1-1939 to 5-27-39  
I last saw h. .... alive on 5-27-39 Death is said to have occurred on the date stated above, at 4 P m.  
The principal cause of death and related causes of importance were as follows:  
Pulmonary abscess Date of onset 4/1/39  
23  
Other contributory causes of importance: Pulmonary T. B.  
Name of operation ..... Date of .....  
What test confirmed diagnosis? X-Ray 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? no  
If so, specify  
(Signed) O. J. Bohrer M. D.  
(Address) Lebanon Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Eldon Mo DATE 5/29/39  
19. FUNERAL DIRECTOR (ADDRESS) W.E. Holman  
Lebanon Mo  
20. FILED 5-29-39 J.R. McCoub Local Registrar.

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.

50M-750-37  
I X 12004

RECEIVED

District Health Officer No. 7,

District File Number 7-39-929

Date Filed 6-8-39

STATEMENT BY LICENSED EMBALMER

I, Carl W Hause, Licensed Embalmer No. 3955

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Carl W Hause

Licensed Embalmer No. 3955

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