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

1686
Do not use this space.

FILED JAN 24 1940

1. PLACE OF DEATH 3 85
(a) County BUCHANAN Registration District No.
(b) Township 0 Primary Registration District No. 1001 Registered No. 17
or
(c) City ST. JOSEPH (d) Street No. Entering Mo. Meth Hosp. 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 40 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 152 ROY-GEORGE-ROBBINS.
(a) Residence, No. 902 NORTH 2ND 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: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Effie Robbins

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 24 1891

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
48	9	11	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. P. A. 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) Jan 4 - 1940
11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Davis City Iowa

FATHER
13. NAME Charles V. Robbins
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Davis City Iowa

MOTHER
15. MAIDEN NAME Lucindia Goodin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do Not Know Kansas

17. INFORMANT (ADDRESS) Effie Robbins St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Pleasant Ridge Cem DATE Jan. 8 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roy Stamey St Joseph Mo

20. FILED 1/8 1940 H J Matthews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 5th 1940

22. I HEREBY CERTIFY, That I ~~attended~~ Viewed deceased from Jan 5th 1940, to ..., 19...
I last saw h ####### alive on ..., 19... Death is said to have occurred on the date stated above, at 8.20 m. A, M,
The principal cause of death and related causes of importance were as follows:

	Date of onset
Mitral Insufficiency	
9-2-4	

Other contributory causes of importance: none

Name of operation ..... Date of .....
What test confirmed diagnosis? History 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) B. W. Tadlock Coroner, M. D.
(Address) King Hill Bldg

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED FILED STATE OFFICE
UNDER CARD RETURNED TO DISTRICT
DATE 4-7-

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 John Roy Stanley

Licensed Embalmer No. 2435

P. O. Address St Joseph Mo

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

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