

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 97

1. PLACE OF DEATH:

(a) County Jasper
 (b) City or town Carthage, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Stone Memorial Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 hours
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Travis Wayne Robison

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 9, 1933
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>8</u>	<u>4</u>	<u>10</u>	_____ hr. _____ min.

9. Birthplace Weniert, Texas
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name Jackson C. Robison

13. Birthplace Rose Bud, Texas
 (City, town, or county) (State or foreign country)

14. Maiden name Reta Douty

15. Birthplace Eperton, Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Jackson C. Robison

(b) Address Commerce, Oklahoma

17. (a) Burials Creek (b) Date thereof June 21, 41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sinkingg Creek

18. (a) Signature of funeral director J. W. Ward

(b) Address Peacefield, Mo

19. (a) June 21, 1941 (b) E. J. McIntire, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
 (c) City or town Carthage, Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
 year 1941 hour 3:4 minute 00 P.M.

21. I hereby certify that I attended the deceased from June 19
 1941, to _____, 1941;

that I last saw him alive on June 19, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebro-spinal meningitis

Due to Acute mastoiditis

Due to _____

Other conditions 0
 (Include pregnancy within 3 months of death)

Major findings: None
 Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

8 to 5 (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature A. F. Stagers, Jr. (M. D. or other) D.D.

Address Eperton, Mo. Date signed 6/20/41

Duration

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

41-7-633

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.....

J. W. Ward

Licensed Embalmer No..... *2832*

P. O. Address..... *Greenfield, Ma*

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.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 97

1. PLACE OF DEATH: Jasper
 (a) County _____
 (b) City or town Carthage
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Stone Memorial Hospital
 (If not in hospital or institution, write street number or locality) _____ hrs.
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULLNAME Travis Wayne Robison
 3. (b) If veteran, name war -- 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Feb. 9, 1933
 (Month) (Day) (Year)

8. AGE: Years 8 Months 4 Days 10
 If less than one day _____ hrs. _____ min.

9. Birthplace Texas
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

20. DATE OF DEATH: Month June day 19
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Improbable cause of death _____ Duration _____

Due to Cerebro-spinal-meningitis
acute mastoiditis

Due to MENINGOCOCCUS

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: NO
 Of operations _____

Of autopsy NO

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. F. Steyer (M.D. or other) DO

Address Evans Mo. Date signed 12/19/34

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

