

FILED MAY 26 1948

State File No. \_\_\_\_\_

Registration District No. 20

Primary Registration District No. 4031

Registrar's No. 42

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

**1. PLACE OF DEATH:**

(a) County Bates

(b) City or town Adrian  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 62 years years, months or days

**8. (a) PRINT FULL NAME** John D. Robinson

3. (b) If veteran, name war X

3. (c) Social Security No. X

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 August 19 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>9</u>	<u>I</u>	_____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name W. Sterling Robinson

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

14. Maiden name Synthia Ann Jones

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

16. (a) Informant Mrs. Maude Teeter

(b) Address Adrian Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 5-23-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Creath & Sif

(b) Address Adrian Mo.

19. (a) 5-22-48 (Date received local registrar)

(b) Mapa Owens (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Bates

(c) City or town Adrian  
(If outside city or town limits, write "RURAL.")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 20  
year 1948 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 18 - 1947 to 20 May 1948  
that I last saw him alive on 5-14-48 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Toxemia several

Due to Banana slices of  
with feet

Due to diabetes

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations No

Of autopsy No

Duration \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence No

(c) Where did injury occur? No  
(City or town) (County) (State)

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

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Chelloodrick (M. D. or other)  
Address Adrian, Mo. Date signed May 22

RECEIVED  
District Health Officer No. 7;  
District File Number \_\_\_\_\_  
Date Filed \_\_\_\_\_

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. 3650

P. O. Address Adrian Mo

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, above space should be left blank.