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

PLACE OF DEATH

County: DeKalb

Township: Grant
or
Village:
or
City: (NO. St.: Ward)

Registration District No. 264
Primary Registration District No. 5367

File No. 34697
Registered No. 17

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Inft. (Robinson)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male
COLOR OR RACE: White
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: July (Month) 20 (Day), 1916 (Year)

AGE: 1 yrs. 3 mos. ds.
If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: 0
(b) General nature of industry, business, or establishment in which employed (or employer): 0

BIRTHPLACE (City or town, State or foreign country): Grant Township, DeKalb Co.

PARENTS
NAME OF FATHER: Samuel Robison
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
MAIDEN NAME OF MOTHER: Ina Hoskins
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Robison
(ADDRESS) King City, Mo.

Filed Oct 27, 1917 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 1 Oct (Month) 27 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 12, 1917, to Oct 27, 1917, that I last saw him alive on Oct 26, 1917, and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:
Tubercular Miningitis
24B

20 (Duration) yrs. mos. 15 ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) W. J. Clark M. D.
Oct 27 1917 (Address) Maysville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Country Cemetery
DATE OF BURIAL: Oct 29, 1917
UNDERTAKER: J. L. Davies
ADDRESS: Maysville, Mo.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.: _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191___, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191___
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191___, to _____, 191___, that I last saw h_____ alive on _____, 191___, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191___ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191___
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be given [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.