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.

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

PLACE OF DEATH

County Montana

Township Harrison

or

Village

or

City (NO. St.: Ward)

Registration District No. 576

Primary Registration District No. 5773

File No. 23949

Registered No. 8

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

FULL NAME Frank S. Robinson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Colored

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Oct 11 (Month) (Day), 1864 (Year)

AGE: 53 yrs. 9 mos. 5 ds.

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

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

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

BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS

NAME OF FATHER: Jack Robinson

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

MAIDEN NAME OF MOTHER: Irene Johnston

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Frank Robinson

(ADDRESS) Eldon Mo

Filed Sept 10, 1918. Wm H. Finke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 16 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from July 15, 1918, to July 16, 1918, that I last saw him alive on July 15, 1918, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

79

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

8 (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G A Leslie M. D.

8/9 1918 (Address) Olean Mo

*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: Green Ridge Cem

DATE OF BURIAL: 7/17, 1918

UNDERTAKER: W G Phillips

ADDRESS: Eldon

PLACE OF DEATH

County

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

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

[If death occurred i hospital or instituti give its NAME insti 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

(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) (Ye

I HEREBY CERTIFY, that I attended deceased fr

, 191, to , 191

that I last saw h alive on , 191

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos.

Contributory
(SECONDARY)
(Duration) yrs. mos.

(Signed) M

, 191 (Address)

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

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

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

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD