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 Cook

Township Johnson

or

Village

or

City Humansville Mo. (NO. _____ St.: _____ Ward)

Registration District No. 703 File No. 324059

Primary Registration District No. 5932 Registered No. _____

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

FULL NAME James Huston Robbins

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

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

DATE OF BIRTH: Sept (Month) 14 (Day), 1861 (Year)

AGE: 59 yrs. 11 mos. 29 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: T. E. Robbins

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

MAIDEN NAME OF MOTHER: Lucinda Houston

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Joseph

(ADDRESS) Humansville Mo.

Filed Sept 3, 1921. Helen Beaty Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 3 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw him alive on Sept 2, 1921, and that death occurred, on ~~the date stated above~~ Sept 3, at 2:30 pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 23A

(Duration) 3 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____

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

(Signed) C. N. Hahn M. D.

9-3, 1921 (Address) Humansville 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: Humansville Mo

DATE OF BURIAL: Sept 4, 1921

UNDERTAKER: J. A. Joseph

ADDRESS: Humansville Mo.

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 _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

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

FULL NAME [illegible]

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) 1 (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) _____

SEP 10 1958

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 _____ (Month) _____ (Day) 191__ (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