PLACE OF DEATH

Randolph

hip Silver Creek

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

Registration District No. 731 File No. 24144

Primary Registration District No. 5965 Registered No. 12

(NO. St.: Ward)

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

FULL NAME Rosella Robinson

PERSONAL AND STATISTICAL PARTICULARS

	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
nale	Black	

OF BIRTH

(Month) (Day) (Year)

4 yrs. 10 mos. 19 ds. If LESS than 1 day, hrs. or min.?

PATION
ade, profession, or
ular kind of work

neral nature of industry,
ss, or establishment in
employed (or employer)

IPLACE
r town,
r foreign country) Randolph C. Mo

NAME OF FATHER Bruce Robinson

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

MAIDEN NAME OF MOTHER

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

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

rmant) Bruce Robinson

(ADDRESS) Yates Mo

Sept 9, 1924. J. Bradshaw REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug (Month) 31 (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 15, 1924, to Aug 31, 1924 that I last saw her alive on Aug 23, 1924 and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 21 ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) W. O. Hawkinson M. D.

Sept 1, 1924 (Address) Roanoke

*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
Near Yates	Sept 2, 1924
UNDERTAKER	ADDRESS
A. H. Aldaker	Armstrong

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occur
hospital or in
give its NAME
of street and nu

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

..... ,
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 1

that I last saw h.....alive on....., 1

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).....

....., 191..... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIEN 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
UNDERTAKER	ADDRESS