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

Do not use this space.

30031

1. PLACE OF DEATH
County: Gentry
Township:
City: Albany (No. ..... St. ..... Ward)

Registration District No. 309
Primary Registration District No. 4185

File No.
Registered No. 39

2. FULL NAME: Rebecca Jane Robison

(a) Residence. No. ..... St. ..... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Widow of Samuel Robison

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May the 13 - 1837

7. AGE: Years 90 | Months 5 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Tenn

PARENTS

10. NAME OF FATHER: Ann McNatt
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Sarah McNatt ~~Dont Know~~
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Dont Know

14. INFORMANT: John Newman
(Address): Albany, Mo

15. FILED Nov 2, 1927. W. T. Martin, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 29 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 1927, to Oct 29, 1927, that I last saw h... alive on Oct 1-9, 1927, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
8 days
1 hr 7 Hrs (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY)
age (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Jas N Barger, M. D
11/1, 1927 (Address) Albany Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Berlin Cemetery
DATE OF BURIAL: Oct 30 1927

20. UNDERTAKER: F R Hockley
ADDRESS: Albany Mo

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.

PERMANENT RECORD