

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

Do not use this space.

11903

MAR 21 1928

1. PLACE OF DEATH

County..... Scott Registration District No..... 820 File No..... 7
Township..... Shawana Primary Registration District No..... 6269 Registered No..... 759
City..... Osage (No.....) St..... (Ward)

2. FULL NAME

Martin 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/9/28
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min. 1 20
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work _____
(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)

Mo
10. NAME OF FATHER Wm J Robison
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ten
12. MAIDEN NAME OF MOTHER Mattie Fallin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT Wm J Robison
(Address) 10 2nd Ave

15. FILED 29, 1928 W. H. Robison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/1 1928
17. I HEREBY CERTIFY, That I attended deceased from 1/9, 1928, to 3/1, 1928 that I last saw him alive on 2/27, 1928, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congestive Debility
1.57
1.57 (duration) yrs. 1 mos. 22 ds.
CONTRIBUTORY (SECONDARY) Premature Birth
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 0/16/28
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) J. A. Crane, M. D.
, 1928 (Address) Osage 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 Friend Cemetery DATE OF BURIAL 3/2 1928
20. UNDERTAKER W. H. Robison ADDRESS

K. R.—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.

11/18/11

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott
Township Wesleyville
City Wesleyville (No.)

Registration District No. 820
Primary Registration District No. 6069

File No.
Registered No.
St. Ward

2. FULL NAME

Martin Rabison

(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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-9-28

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
		<u>1</u>	<u>20</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(c) Name of employer

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 3-9-28 L. J. Shuman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1 19 28

17. I HEREBY CERTIFY That I attended deceased from 19, 19, that I last saw him alive on 19, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M. D.
, 19 (Address)

*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 DATE OF BURIAL

Greenwood Cem 3-2 19 28

20. UNDERTAKER ADDRESS W. H. Henshaw & Co

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. —Exact statement of OCCUPATION is very important REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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