

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

Do not use this space.

36904
4553

1. PLACE OF DEATH

County Franklin
Township Franklin
City Lebanon, Mo. (No. 710 East 6th) St. _____ Ward _____

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____

2. FULL NAME

Lavinia Robinson (Doris Robinson)
(a) Residence. No. 710 E. 6th 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 F 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) 12-30-25

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
2 10 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed (or employee) Merch
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Kans

14.

INFORMANT Edward Robinson
(Address) 710 E 6th

15.

FILED 11-28 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-28

17. I HEREBY CERTIFY That I attended deceased from Nov. 18 to Nov 18 1928 that I last saw her alive on Nov. 17 1928 and that death occurred, on the date stated above, at 7:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumo-pneumonia
(duration) _____ yrs. _____ mos. 5 ds.
CONTRIBUTORY Whooping cough
(SECONDARY) (duration) _____ yrs. _____ mos. 15 ds.

18. WHERE THIS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Thos. D. Jones M. D.

(Address) 710 E 6th St

*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

Wald Ridge 11/12 1928

20. UNDERTAKER

ADDRESS

J. B. Moore 1820 E. 8th

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.

