

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

Do not use this space.

1. PLACE OF DEATH
 County Wapehannock Registration District No. 125 File No. 9829
 Township Wapehannock Primary Registration District No. 2009 Registered No. 77
 City St. Francis Hospital St. _____ Ward)

2. FULL NAME Cassie Robinson
 (a) Residence. No. Charleston, Mo. Ward. _____ (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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Robinson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
34
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)
 10. NAME OF FATHER Benjamin Lynch
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Ida Lucas
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known (STATE OR COUNTRY)
 14. INFORMANT William Robinson (Address) Charleston, Mo.
 15. FILED 3/15/29 W. Haupp REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15-1929
 17. I HEREBY CERTIFY, That I attended deceased from 3-15-1929 to 3-15-1929 that I last saw him alive on 3-15-1929 and that death occurred, on the date stated above, at 2:45 P.M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Unknown Cause all over body from oil stain
27 hours
 (duration) _____ yrs. _____ mos. 34 ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED Charleston, Mo.
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Physical
 (Signed) W. H. Hoke, M. D.
7-15-1929 (Address) Wapehannock
 *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 Charleston, Mo. DATE OF BURIAL 3/16-1929
 20. UNDERTAKER Lair Undertaking Co. ADDRESS Charleston, Mo.

N. B.—Every item of information should be carefully supplied. Where space is not available, use reverse side. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

2
 24
 235
 2
 31
 31

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

7829
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape Gir. Registration District No. 125 File No.
Township Primary Registration District No. 3009 Registered No.
City (No.) St. Ward)

2. FULL NAME

Carrice Robinson

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15-1929

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

External burns all over body from oil stove explosion

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

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH.....
I do not know why they are building burned out.

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

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

10. NAME OF FATHER

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) S. J. Cape M. D.
5-17, 1929 (Address) Cape Girardou, Mo

12. MAIDEN NAME OF MOTHER

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

*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
19

15. FILED 5/18 1929 C. Kaempfer REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-9829