

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

Do not use this space.

22006

1929

315  
5287

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

PLACE OF DEATH  
County McDonald Registration District No. \_\_\_\_\_  
Township Prairie Primary Registration District No. \_\_\_\_\_  
City Southwest City Route #2  
2. FULL NAME Martha Elizabeth 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 23rd 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
60 2 5

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) Housework  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St Clair County Missouri  
(STATE OR COUNTRY)

PARENTS  
10. NAME OF FATHER John Teele  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Mira Blevins  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tennessee  
(STATE OR COUNTRY)

14. INFORMANT W.A. Robison  
(Address) Southwest City Mo R72

15. FILED 6/29 1929 J. J. Nichols REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June-28 1929

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 28, 1929, that I last saw her alive on June 28, 1929 and that death occurred, on the date stated above, at 5 P.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Articular Rheumatism and Pneumonia congestion of entire right Lung  
Rheumatism 33 years (duration) yrs. mos. ds.

CONTRIBUTORY Pneumonia, 15 days (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED XXXXX 108 57A  
IF NOT AT PLACE OF DEATH ZZZZZZ

DID AN OPERATION PRECEDE DEATH? DATE OF ZZZZZZ

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS ZZZZZ

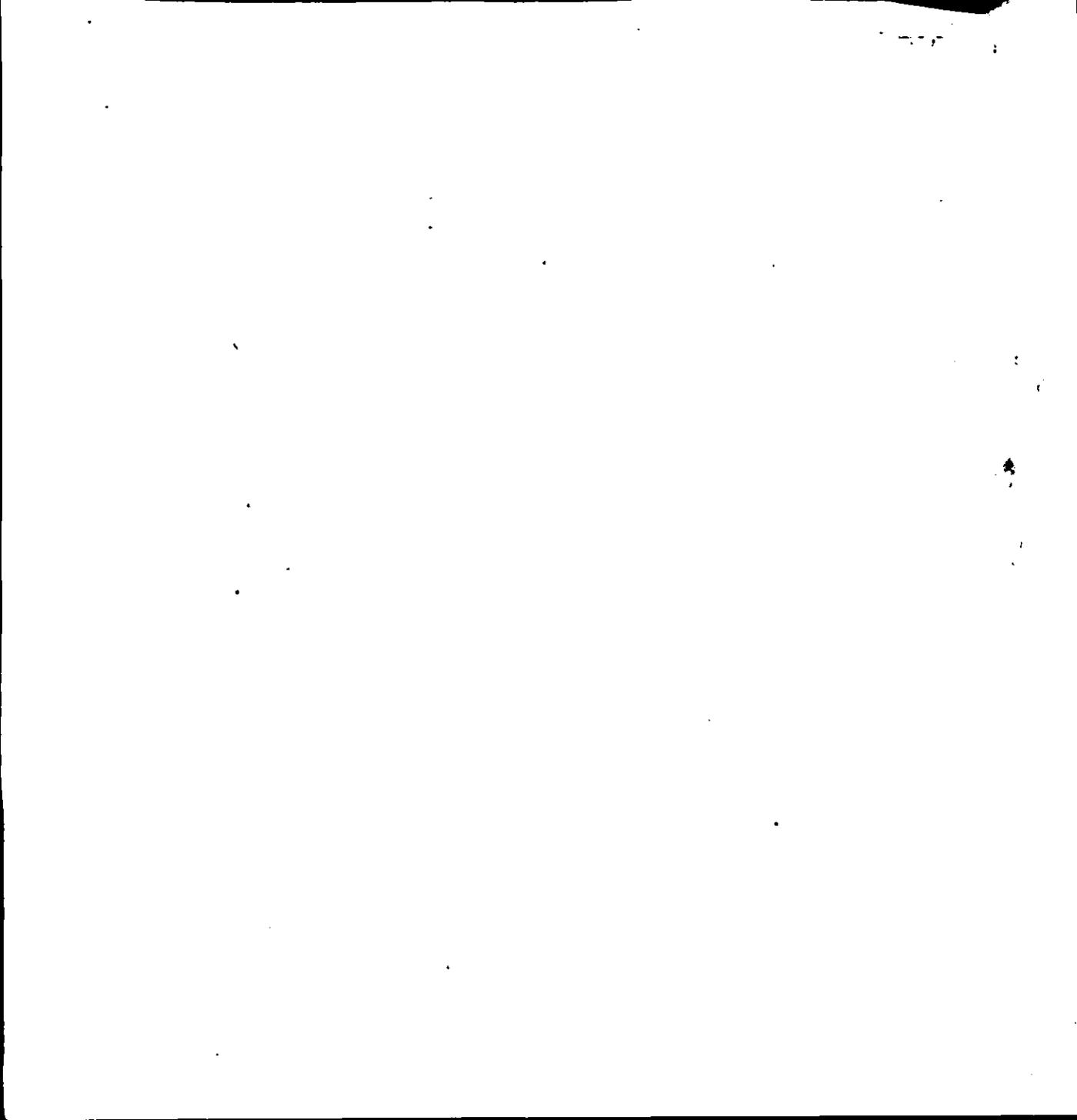
(Signed) W. H. Ingram M. D.

, 19 (Address) Southwest City 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 DATE OF BURIAL  
Southwest City Cemetery 6/29th 1929

20. UNDERTAKER'S ADDRESS  
Nichols Brother Southwest City Mo



**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 McDonald  
Township Pravie  
City (No. ....) St. .... Ward .....

Registration District No. 315-  
Primary Registration District No. 3687

File No. ....  
Registered No. ....

**2. FULL NAME**

Martha Elizabeth 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 ..... 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) .....

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

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

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

**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) .....

PARENTS

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 8/19/29 John J. Nichols REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1929

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.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

20. UNDERTAKER

ADDRESS

RE-SCRIBE BY LAW

A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS

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# 22006  
1929