WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

FEB 19 1929

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

Do not use this space.
1944

1. PLACE OF DEATH
County: Miss
Township: Tywappity
City: ..... (No. ....., ... St. ..... Ward)
Registration District No.: 566
Primary Registration District No.: 5762
File No.: 7
Registered No.: .....

2. FULL NAME: G. W. Robison
(a) Residence. No. ..... St., ... Ward. ~~Dexter~~ Parma - Mo
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Bl
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): 1865

7. AGE: about 65 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer): 131 133C
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Water Valley Miss.

PARENTS
10. NAME OF FATHER: Isom Robison
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mississippi
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: John Robinson
(Address): Parma Mo RFD #1

15. Filed Jun 17th 1930 F S Vernon REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jun 16th 1930

17. I HEREBY CERTIFY, That I attended deceased from treated by Dr Hupp Dexter Mo ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Unknown presumed to be from Chronic nephritis
Dr Hupp at Dexter Mo treated him for kidney trouble
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Chronic nephritis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? History of case
(Signed) Frank S Vernon, M. D.
, 19 (Address) Charleston Mo Coroner

*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: Oak Grove Cemetery
DATE OF BURIAL: 1/17 1930

20. UNDERTAKER: No Undertaker employed
ADDRESS: