

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

Do not use this space.

7408  
7541

**1. PLACE OF DEATH**

County Stoddard Registration District No. 837  
 Township Caster Primary Registration District No. 6099  
 City (No. St. Ward)

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME** Newman A. 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**

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 4 22

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work none  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

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

10. NAME OF FATHER Leander Robinson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Will Robinson  
 (Address) Idalia, Mo.

15. FILED 27 1930 REGISTRAR  
Feb 20 30

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) \_\_\_\_\_ 19\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from 1-29-30 to 2-2-30, 1930  
 that I last saw him alive on 2-2-30, and that death occurred, on the date stated above, at 5:30 p. m.

104 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Lobar Pneumonia  
 (duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) 10/A  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home  
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

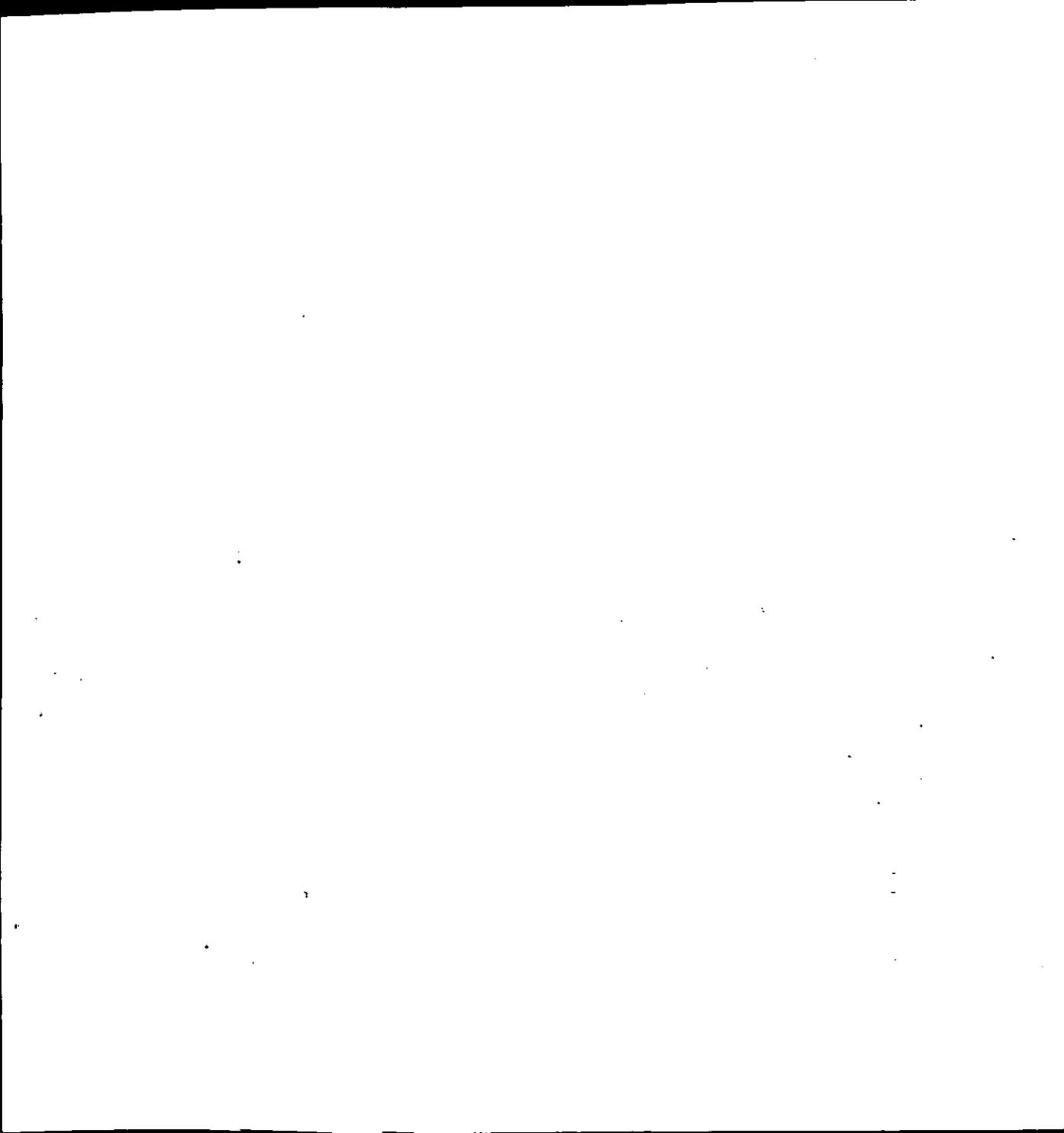
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) J. P. Brandon, M. D.  
 19\_\_\_\_ (Address) Essex, 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 Triplet Cem DATE OF BURIAL 2-24-30

20. UNDERTAKER None ADDRESS \_\_\_\_\_



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH  
 County Stoddard Registration District No. 889 File No. ....  
 Township Caster Primary Registration District No. 6099 Registered No. ....  
 City (No. ....) St. .... Ward)

2. FULL NAME Newman A. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10-1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>93</u>	<u>4</u>	<u>22</u>	

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)

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)

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-2 1930

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 ..... (duration) ..... yrs. .... mos. .... da.  
 CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... da.

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.

14. INFORMANT (Address) Feb 30 Edw Ford

15. FILED 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 2-4 1930

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-7408