

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

Do not use this space.

11349

APR 30 1930

**1. PLACE OF DEATH**

County Shelby  
Township Jackson  
City Jackson (No.         )

Registration District No. 898  
Primary Registration District No. 2040

File No.           
Registered No.           
St.          Ward         

**2. FULL NAME**

H. G. Robbins

(a) Residence No.          St.          Ward           
(Usual place of abode)

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-2-1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 5 17

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Marion Co  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Adon A. Robbins

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

12. MAIDEN NAME OF MOTHER Louisa M. Hadloff

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

14. INFORMANT Alice M. Robbins  
(Address) Lakewood 920

15. FILED 3/20 30 Dr. C. T. White  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 19 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to Mar 19, 1930 that I last saw h..... alive on Feb 26, 1930, and that death occurred, on the date stated above, at 1:45 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Valvular heart disease  
97 A

CONTRIBUTORY (SECONDARY) infarct  
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF           
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) R. H. Parker, M. D.

, 19 (Address) Sumnerville 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 Graves Vicar Cem. DATE OF BURIAL 3/21 1930

20. UNDERTAKER Groves & Gowan ADDRESS Wasson Blvd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

84  
1  
1  
2

should state  
injection

ACTIV. PHN  
CORPOR.

carefully so

B. Every item  
OF DR

**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 Shelby Registration District No. 828 File No. ....  
Township Jackson Primary Registration District No. 6040 Registered No. ....  
City ..... (No. ....) St. .... Ward)

**2. FULL NAME**

H. C. Robbins

(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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-2-1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
84 3 17

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
(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) .....

14. INFORMANT ..... (Address) .....

15. FILED 3/20/1930 Dr. C. T. White REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 19 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) ..... (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 19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

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