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

Do not use this space.
20442
~~20540~~

1. PLACE OF DEATH

County St. Francois — Registration District No. 773
Township St. Francois — Primary Registration District No. 6018.A
City ~~Farmington, Mo.~~ (No. ..... St. ..... Ward)

File No. .....
Registered No. 94

2. FULL NAME Thomas John Robinson

(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode) Bragg City, Mo.
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)
Male	White	Married

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
79	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(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) Pennsylvania

PARENTS
10. NAME OF FATHER Unknown
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 Hospital Records
(Address) Farmington, Mo.

15. FILED 6-22 1930 B. J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-18-30 19

17. I HEREBY CERTIFY, That I attended deceased from 6-11, 1930, to 6-18, 1930, that I last saw him alive on 6-17, 1930, and that death occurred, on the date stated above, at 3:45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
931
97 (duration) 10 yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis
..... (duration) 15 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) J. C. Tincher, M. D.
6-18, 1930 (Address) Farmington, 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 Hospital Cemetery — DATE OF BURIAL 6-20 1930
20. UNDERTAKER State Hosp No 4 (Dolby) — ADDRESS Farmington Mo

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.