DEC 20 1930

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

Do not use this space.

85

35457

File No.

Registered No. 1247

1. PLACE OF DEATH

County Buchanan. Registration District No.

Township Primary Registration District No. 1001

City St. Joseph (No. Enroute to Noyes Baptist Hospital St. Ward)

2. FULL NAME Lenore Ralph Robison

(a) Residence. No. 1907 Union St. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 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 Lillie Robison

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 17, 1900

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer M. L. Robison

9. BIRTHPLACE (CITY OR TOWN) Helena
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER G. F. Robison

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

12. MAIDEN NAME OF MOTHER Fannie Farrington

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

14. INFORMANT Mrs Lillie Robison
(Address) 1907 Union St.-St. Joseph Mo.

15. FILED NOV 1 9 1930 John L. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Viewed on 11-18, 1930, to, 19, that I last saw h alive on, 19, and that death occurred, on the date stated above, at not stated m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
936
1930
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Acute Indigestion
(duration) 1 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? Yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) B. W. Tadlock Coroner M. D.
Nov. 18. 19 30 (Address) 821 Francis

*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 Helena Mo.
DATE OF BURIAL Nov. 20 19 30

20. UNDERTAKER H. O. Siebenfaden
ADDRESS 1802 Union St.

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.