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

Do not use this space. (1)

40043 A

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

1. PLACE OF DEATH
County: Macon
Township: Gaffey
City: ~~Gifford~~ (No. ..... St. ..... Ward)
Registration District No. 530
Primary Registration District No. 5708

2. FULL NAME: A. W. 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: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (~~OR WIFE OF~~): Becka Robinson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 10 1857

7. AGE: Years 73 | Months 8 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

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): .....
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Creed W. Robinson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Virg
12. MAIDEN NAME OF MOTHER: Hellmina C. Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Germany

14. INFORMANT: W. M. Robinson
(Address): La Plata

15. FILED 1-31-31, 19..... Florence Patrick, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 31 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1930, to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1-45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Accident (Broken neck)
Fell from load of hay
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): 185
(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? Fracture 2 neck
WHAT TEST CONFIRMED DIAGNOSIS? W. L. Clarson
(Signed) J. J. Fallon M. D.
, 19 (Address) La Plata 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: Indian Hill — DATE OF BURIAL: Jan 2 1931
20. UNDERTAKER: W. H. McCollum — ADDRESS: South Gifford

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 20 1931

WARNING: FAILURE TO FILL OUT THIS IS A PERMANENT RECORD