REC'D JUL 17 1939

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

23486
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon 2 Registration District No. 875

(b) Township Badger 1 Primary Registration District No. 6069 Registered No. 145

or

(c) City Nevada (d) Street No. Nevada, Mo RFD 3 St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 17 yrs. 3 mos. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 152 Dorothy Lee Robinson

(a) Residence, No. Nevada, Mo. St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 1, 1922

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

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Invalid

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Nevada, Mo. 0

FATHER

13. NAME John F. Robinson 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Iowa

MOTHER

15. MAIDEN NAME Katie Anderson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milo, Mo.

17. INFORMANT (ADDRESS) Katie Robinson, Nevada, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Newton Cemetery DATE June 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ferry Funeral Home Nevada, Mo

20. FILED 6-8 1939 Allen V Hays Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 4:25 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralysis	
Four days duration	

Other contributory causes of importance:

Brain Tumor

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) M. E. Ferry Coroner, M. D. not an M.D.

(Address) Nevada Mo

(Licensed Embalmer's Statement on Reverse Side)

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X16605

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RECEIVED
District Health Officer No. 7
District File Number 7-39-1036
Date Filed 7-13-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ Personal

....., Registered Apprentice No.....

working under my personal supervision.

Signed Lloyd R. Winnett

Licensed Embalmer No. 3867

P. O. Address Nevada, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23486
Do not use this space.

1. PLACE OF DEATH
(a) County Vernon — Registration District No. 875
(b) Township Badger — Primary Registration District No. 6161 — Registered No.
(c) City — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dorothy Lee Robinson
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED — 19 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6 - 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....19.., to ....19..
I last saw h.... alive on ....19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Paralysis	
Four days duration	
Unknown	
M E Ferry Coroner	
	55 d

Other contributory causes of importance: Brain Tumor

Name of operation — Date of
What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury ....19..
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) M. E. Ferry Coroner, M. D.
(Address) Nevada Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY

SEP 13 1988