

1939 OCT 12 1939

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

32019
Do not use this space.

1. PLACE OF DEATH
 (a) County Callaway 3 Registration District No. 104
 (b) Township Fulton 1 Primary Registration District No. 3008 Registered No. 256
 (c) City Fulton (d) Street No. State Hoop # 1 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 Wynnan Robinson (Colored)
 (a) Residence, No. Tabette 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DK.
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 mos DK DK DK
 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. none
 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) Missouri
 13. NAME DK.
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK
 15. MAIDEN NAME DK.
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK.
 17. INFORMANT (ADDRESS) State Hoop # 1 - record
 18. BURIAL, CREMATION, OR REMOVAL PLACE Hospital grounds DATE Sept 14 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. C. Phoyssi 302 Market St Fulton Mo.
 20. FILED Sept 14, 1939 R. N. Crews 10 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 12 1939
 22. I HEREBY CERTIFY, That I attended deceased from Aug 9 1939 to Sept 12 1939
 I last saw him alive on Sept 12 1939 Death is said to have occurred on the date stated above, at 4:15 p.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
Arteriosclerosis, Generalized
 Other contributory causes of importance: Smoking
 Name of operation _____ Date of _____
 What test confirmed diagnosis Autopsy Was there an autopsy? Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No. 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? No
 If so, specify _____
 (Signed) Wm. J. Wood M. D.
 (Address) State Hoop # 1 Fulton 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.

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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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