

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

4041
Do not use this space.

REC FEB 15 1940

1. PLACE OF DEATH
 (a) County Lucevin Registration District No. 2-3
 (b) Township Olney Primary Registration District No. 7-17
 or
 (c) City Newtown (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 Woodrow Dale Robinson
 (a) Residence, No. _____ 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 M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 11 1912

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. min.
	<u>27</u>	<u>3</u>	<u>8</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18 1940

22. I HEREBY CERTIFY that I attended deceased from Jan 1 1939 to Jan 18 1940
 I last saw him alive on Jan 18 1940 Death is said to have occurred on the date stated above, at 10.0 a.m.
 The principal cause of death and related causes of importance were as follows:
Chronic Myocard
from Birth
 Date of onset _____

Other contributory causes of importance: Alc. Colitis Jan 4-1940

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) A. W. Widner M. D.
 (Address) Newtown Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merces
Merces Co. Mo

FATHER
 13. NAME Robert Robinson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merces Co Mo

MOTHER
 15. MAIDEN NAME Augusta Strauser
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Putman Co Mo

17. INFORMANT Mrs. Florence Robinson
 (ADDRESS) Newtown Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Brantley DATE Jan 21 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Judd Payne
Newtown Mo.

20. FILED Jan 23 1940 Wm. R. Hines
 Local Registrar

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.

RECEIVED

District Health Officer No. 10

District File Number 2-40-416

Date Filed FEB 13 1940

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.