

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

43520
 Do not use this space.

727 JAN 25 1940

1. PLACE OF DEATH
 (a) County Boone Registration District No. 6300
 (b) Township Springfield Primary Registration District No. 5408 Registered No. _____
 (c) City _____ or _____ (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. () How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Edward Robbins
 (a) Residence, No. _____ (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 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 Constance Robbins
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6, 1894
 7. AGE YEARS 46 MONTHS 3 DAYS 25 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. Farming
 10. Date deceased last worked at this occupation (month and year) Oct 1940 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME Lee Roy Robbins
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merioux, Mo

MOTHER 15. MAIDEN NAME Hannah Cook
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Merioux, Mo

17. INFORMANT (ADDRESS) Geo. Robbins

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Andrew Cem. DATE Nov 2, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) 1012

20. FILED Jan 1, 1940 Alpha Coffe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1939, to Oct 31, 1940, 1940
 I last saw him alive on Oct 31, 1940. Death is said to have occurred on the date stated above, at 7:07 m.
 The principal cause of death and related causes of importance were as follows:

Chronic Nephritis Date of onset 1939

Other contributory causes of importance: 191

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

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? no
 If so, specify _____

(Signed) V. L. Reed M. D.
 (Address) 700 King St

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

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. 5,

District File Number 6240116f

Date Filed _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 47520

Registration District No. 680

Primary Registration District No. 5908

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Spring Creek T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Edw Robbins

3. (b) If veteran name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 46 Months 3 Days 25 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct. 31, 1940 (b) Alpha Capps (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Phelps

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 31 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw h. _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature W. L. Reed (M. D. or other) _____

Address Licking _____ Date signed _____

SUPPLEMENTARY

S-43520