DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 5 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35546

Registration District No. 566 Primary Registration District No. 5762 Registrar's No. 115

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

1. PLACE OF DEATH:

(a) County MISSISSIPPI
(b) City or town CHARLESTON - RURAL
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R#2 Box 124 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 9 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MISSISSIPPI 67
(c) City or town CHARLESTON 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ✓ 0

3. (a) PRINT FULL NAME LONNIE ROBINSON

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race Bl. COLOR

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

6. (b) Name of husband or wife IANTHA ROBINSON

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased MARCH (Month) 25, (Day) 1879 (Year)

8. AGE: Years 62 Months 6 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation FARMER

11. Industry or business FARMING

FATHER
12. Name NEAL ROBINSON
13. Birthplace (City, town, or county) GEORGIA (State or foreign country)

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace (City, town, or county) NOT KNOWN (State or foreign country)

16. (a) Informant IANTHA ROBINSON
(b) Address CHARLESTON, MO R#2 Bx124

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-13-1941 (Month) (Day) (Year)
(c) Place: burial or cremation OAK GROVE, CHARLESTON, MO

18. (a) Signature of funeral director LAIR-NUNNELEE
(b) Address CHARLESTON, MO

19. (a) 10-22-41 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 11TH year 1941 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 7, 1941, to Oct 11, 1941; that I last saw him alive on Oct 11, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardio Renal disease	D.K.
Due to	
Due to	
Other conditions Asthma (Include pregnancy within 3 months of death)	DK
Major findings: Of operations none	
Of autopsy	

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 0

23. Signature E. Chas Koliving (M. D. or other)
Address Charleston, Mo Date signed 10-14-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 1941-1482

Date Filed 11/3/41

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 John F Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, Mo

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, fact should be so stated above.

. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35546

Registration District No. 564 Primary Registration District No. 5762 Registrar's No.

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Rural
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lonnie Robinson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race B
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 Mar. (Month) 25 (Day) 1879 (Year)
8. AGE: Years 62 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Tenn (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) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-41 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery
18. (a) Signature of funeral director
(b) Address
19. (a) 12-12-41 (Date received local registrar) (b) Frank S Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day
year 1941 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

Certificate No. 5

S-35546