No. 2
-9-4-41
-17-39
X29484

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

...MENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1943

Registration District No. 183

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

35147

State File No.

Primary Registration District No. 5686

Registrar's No. 34

1. PLACE OF DEATH:
(a) County: Linn
(b) City or town: Locust Creek Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Linn Co. Infermery
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days)
In this community 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Linn 059
(c) City or town: Linn Co. Infermey 0 0
(If outside city or town limits, write "RURAL")
(d) Street No.: 1 mi. west of Linneus, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: n

3. (a) PRINT FULL NAME: MARION DOUGLAS ROBISON

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: 1

6. (b) Name of husband or wife: Bertha Mae Robison

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: Feb. (Month) 25 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	3	26	hr. min.

9. Birthplace: Sullivan Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Day laborer

11. Industry or business:

FATHER
12. Name: Not known
13. Birthplace: not known (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: Not known
15. Birthplace: Not known (City, town, or county) 9 (State or foreign country)

16. (a) Informant: W. R. Robison
(b) Address: 183705 Pueblo. Colo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-23-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Meadville, Cem

18. (a) Signature of funeral director: McSharne
(b) Address: Laclede, Mo.

19. (a) 10/25-1943 (Date received local registrar) (b) Mrs. C.C. Wooff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21 year 1943 hour 10 minute — A.M.

21. I hereby certify that I attended the deceased from March 15, 1937, to Oct 15, 1943 that I last saw h... alive on Oct 19, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Nephritis	8 yr
Due to: Chronic Arteriosclerosis	21 yr
Due to:	
Other conditions (Include pregnancy within 3 months of death): 131	
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: 0

23. Signature: Roy R. Haley (M. D. or other) M.D.
Address: Brookfield Mo Date signed: 10-23-43

1334 (Licensed Embalmer's Statement on Reverse Side)

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 Me McThane, Registered Apprentice No. 2876 working under my personal supervision.

Signed: McThane

Licensed Embalmer No. 2876

P. O. Address Laclede, Mo.

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

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Non.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Co. Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 yr. (Specify whether years, months or days)

In this community 25 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (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: Marion D. Robison

3. (b) If veteran, name war: .....

3. (c) Social Security No. [redacted]

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: .....

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: Feb. (Month) 25 (Day) 1871 (Year)

8. AGE: Years 72 | Months 3 | Days ..... | If less than one day ..... min.

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

10. Usual occupation: .....

11. Industry or business: .....

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

MOTHER
14. Maiden name: .....
15. Birthplace: ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant: .....
(b) Address: .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation: .....

18. (a) Signature of funeral director: .....
(b) Address: .....

19. (a) 10/23/1943 (Date received local registrar) (b) Mrs C C Wood (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24 year 1943 hour ..... minute ..... M.

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

Immediate cause of death: ..... Duration

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 .....

35147