

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.

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

FILED JAN 16 1945

2770

Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 176
(b) Township Red Oak Primary Registration District No. 36 57
(c) City (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 Clay Leroy 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22 - 1912
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
32 4 12
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. farmer
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) Osage Co. Mo.

FATHER 13. NAME Ray T. Robinson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT (ADDRESS) Mrs. Clay Robinson Golden Bldg

18. BURIAL, CREMATION, OR REMOVAL PLACE Indwell DATE Jan 6 1945

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Aldred

20. FILED 146 1945 Anna Whinnery Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 3 1945

22. I HEREBY CERTIFY, That I attended deceased from after death 19..... to..... 19.....

I first saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 8:00 A.M.

The principal cause of death and related causes of importance were as follows:

Suicide by hanging

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? ✓ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide suicide Date of injury 1/3 1945

Where did injury occur Lawrence County (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

in barn near home

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Herman Surridge coroner

(Address) Aurora Mo

1912

8/27/44
1912/3

RECEIVED

District Health Officer No. 6

District-File Number 145-28

Date Filed JAN 11 1945

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, ~~on~~ by _____

Registered Apprentice No. _____

working under my personal supervision.

Signed *E. Caldwell* _____
Licensed Embalmer No. 3380

P. O. Address *Lakewood, 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, above space should be left blank.