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

Do not use this space.

/ 2447

1. PLACE OF DEATH

County St. Francois

Township " "

City Flat River

Registration District No. 774

Primary Registration District No. 6018 B

File No. 94

Registered No.

(No. ..... St. ..... Ward)

2. FULL NAME Premature Baby Roper

(a) Residence. No. ..... St., ... Ward.
(Usual place of abode)

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-17-30

7. AGE: Years ✓ | Months | Days | If LESS than 1 day, ... hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Flat River Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Willard Roper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Hazel Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Willard Roper
(Address)

15. FILED Jan 27, 1930 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-17 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-17-, 1930, to 1-17, 1930 that I last saw h... alive on 1-17, 1930 and that death occurred, on the date stated above, at 5:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth

159 Lived - 30 min

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Same

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? D.R.

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W J Bryan, M.D

1-18, 1930 (Address) Flat River Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH:
County St Francois — Registration District No. 974 — File No. .....
Township ..... — Primary Registration District No. 4465 — Registered No. 94
City Flat River (No. ....., ... St. ..... Ward)

2. FULL NAME Infant Roper
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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

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

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19..... W. A. Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan - 17 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....(duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

.....(duration)..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: K. P. Cemetery — DATE OF BURIAL: Jan. 17 1930

20. UNDERTAKER: Nave. Premature — ADDRESS

Fetus 6 - 8 mos.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-2447