

REC'D APR 17 1939

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

No.

Registration District No.

Primary Registration District No.

(No.)

File No.

Registered No.

St.

Ward)

2. FULL NAME *Elijah Roberts*

(a) Residence, No.

(Usual place of abode)

Ward.

(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

4. COLOR OR RACE

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

*male**colored**married*

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

Rose Boyd Roberts

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

5-27-1897

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*41**9**27*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Houseman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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)

Kansas

MOTHER FATHER

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

19. UNDERTAKER (ADDRESS)

20. FILED

DATE

YEAR

MONTH

DAY

SIGNATURE

OF

REGISTRAR

NAME

MEDICAL CERTIFICATE OF DEATH

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

*3-24*19*39*

22. I HEREBY CERTIFY, That I attended deceased from

*3-7*19*39* to*3-24*19*39*I last saw ~~him~~ alive on *3-24*, 19*39*. Death is saidto have occurred on the date stated above, at *6:00* *P.M.*

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

*Coronary Occlusion
& Infarcts of Heart
Kidney & Spleen.*

Other contributory causes of importance:

94B

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? _____

If so, specify _____

(Signed)

J. O. Brown M. D.

(Address)

General Hospital #2

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.

Embraced by

N.B. Moore

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