2468

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

PLACE OF DEATH

County: Pettis

Township ..... or Village ..... or City: Sedalia (NO. 817 W. 3rd St.; ..... Ward)

Registration District No. 668 File No. 18781

Primary Registration District No. 3032 Registered No. 151

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James R. Robertson

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	W.	Married

DATE OF BIRTH: May (Month) 12 (Day), 1887 (Year)

AGE: 29 yrs. ..... mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): R.R. Shops

BIRTHPLACE (City or town, State or foreign country): Morgan County, Mo.

PARENTS
NAME OF FATHER: James L. Robertson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Don't know
MAIDEN NAME OF MOTHER: Nina Young
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Morgan Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. James R. Robertson

(ADDRESS) 817 W. 3rd

Filed May 22 1916 H. B. Lowe REGISTRAR

3. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 20 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 2, 1916, to May 20, 1916; that I last saw him alive on May 15, 1916; and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Heart failure
from bronchopneumonia.

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (SECONDARY): Measles.

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) E. R. Wacker M. D.

May 22 1916 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Crown Hill — DATE OF BURIAL: May 22 1916

UNDERTAKER: McLaughlin Bros. — ADDRESS: Sedalia, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to....., 191....., that I last saw h.....alive on....., 191....., 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.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS