

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

PLACE OF DEATH
County Worth
Township Middlefork Registration District No. 1112 File No. 37350-I
or
Village _____ Primary Registration District No. 6213 Registered No. _____
or
City _____ (NO. _____ St. _____ Ward _____)

FULL NAME

James H. Robertson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE ☐ MARRIED ☒ WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH May 6, 1865
(Month) (Day) (Year)
AGE 62 yrs. 4 mos. 18 ds. (IF LESS than 1 day, ____ hrs. or ____ min.?)

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

Farmer

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

BIRTHPLACE
(City or town, State or foreign country)

Worth Co., Mo.

PARENTS

NAME OF FATHER

Jessie Robertson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo.

MAIDEN NAME OF MOTHER

doubt-know

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

doubt-know.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

Dec. 21, 1917W. F. Barnes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Oct 19, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 19, 1917, to Oct 20, 1917, that I last saw him alive on Oct. 20, 1917, and that death occurred, on the date stated above, at 10:30 am.

The CAUSE OF DEATH* was as follows:

Uremia1371718

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Anaemia and inan-(SECONDARY) tion (Duration) ____ yrs. ____ mos. ____ ds.(Signed) O. P. M. Mills M. D.(Address) Grant City 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

Miller Burial

DATE OF BURIAL

Oct. 26, 1917

UNDERTAKER

Miller

ADDRESS

Worth Mo.

PLACE OF DEATH

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

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

(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 (If file the word)
DATE OF BIRTH	(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)

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 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day) _____, 191____

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

UNDERTAKER

ADDRESS

157 17 27
 1858
 1858
 1858