

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

Do not use this space.

SEP 30 1927

25211  
File No. 151  
Registered No. 300  
St. Ward

**1. PLACE OF DEATH**

County Randolph Registration District No. 735  
Township Moberly Primary Registration District No. 3034  
City Moberly (No. 131 Elizabeth)

**2. FULL NAME**

(a) Residence. No. 131 Elizabeth St., 312 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

Female White Married

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

John H Roberts

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

Dec 13 1872

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

55 9 13

8. OCCUPATION OF DECEASED

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

Mo

10. NAME OF FATHER

James S Griffin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Laura McKinney

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14. INFORMANT

(Address)

John H Roberts  
Moberly

15. FILED

8/28 1927 Thos. J. Fleming  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26<sup>th</sup> 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1927, to Aug 26 1927

that I last saw h.w. alive on Aug 26 1927, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Intestinal Causes

CONTRIBUTORY (SECONDARY)

(duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. Gladys Wright, M.D.

8-28, 1927 (Address) Moberly, 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

Moberly Mo

8-28<sup>th</sup> 1927

20. UNDERTAKER

ADDRESS

Malvern and Low

Moberly

6

**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 Randolph Registration District No. 735- File No. 13-1  
 Township ..... Primary Registration District No. 3034 Registered No. ....  
 City mobility (No. ....) St. .... Ward)

**2. FULL NAME**

Florence M. Roberts

(a) Residence No. .... St. .... Ward. .... (If nonresident give city or town and State)  
 (Usual place of abode)

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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-13-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
54 8 13

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (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)

**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 10-12-27 Thos S Fleming REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 1927

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 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:

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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRATION SHALL NOT BE REQUIRED FOR CERTIFICATES UNTIL THEY ARE COMPLETE. THIS PRESENT FORM IS BY LAW

SUPPLEMENTARY

1252-5