

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.

7 OCT 25 1927

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

Do not use this space.

26783

1. PLACE OF DEATH

County Clay
Township Indian River
City Jeffersonville (No. 88)

Registration District No. 198
Primary Registration District No. 5277a

File No. 26783
Registered No. 129
St. _____ Ward _____

2. FULL NAME

Jason W. Roberts
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Mosby mo
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. _____ da. _____
How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 4, 1927

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate M. Roberts

17. I HEREBY CERTIFY That I attended deceased from Sept 2, 1927, to Sept 4, 1927, that I last saw him alive on Sept 4, 1927, and that death occurred, on the date stated above, at 3:00 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13 - 1852

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAY IF LESS than 1 day, hrs. or min.
73 | 3 | 10

appendicitis ruptured -
121A

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

CONTRIBUTORY (SECONDARY) 117A

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

10. NAME OF FATHER Allen Roberts

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF _____
WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John H. Hae, M. D.
Sept 5, 1927 (Address) Excelsior Springs mo

12. MAIDEN NAME OF MOTHER Martha Tucker

*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.

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

14. INFORMANT (Address) Offie E. Michelson
Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kearney DATE OF BURIAL 9-5 1927

15. FILED 9/4 1927 Y.W. Brown REGISTRAR

20. UNDERTAKER Robert Hope Excelsior Springs

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