

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

Do not use this space.

11172

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 003

City St. Louis Mo No. 3705 Rutger St

File No.

Registered No. 3002

St. Ward)

2. FULL NAME

(a) Residence. No. 3705 Rutger St., 18 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 <u>male</u>	4. COLOR OR RACE <u>Cald</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1881-9-15

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>46</u>	<u>5</u>	<u>78</u>	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Alabama
(STATE OR COUNTRY)

10. NAME OF FATHER Boatman Roberson

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

12. MAIDEN NAME OF MOTHER Phemie Harris

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

14. INFORMANT Martha Roberson
(Address) 3705 Rutger St

15. FILED MAR 17 1923 May C. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 3 1923

17. I HEREBY CERTIFY, That I attended deceased from 2 1923, to 3, 3 1923 that I last saw him alive on 3, 3 1923 and that death occurred, on the date stated above, at 7:40 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
chronic

13 92A (duration) 3 mos. ds.

CONTRIBUTORY Chr. Parenchymatous Nephritis (SECONDARY)
129A (duration) 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED? no
IF NOT AT PLACE OF DEATH:

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Otto I. Walsen, M. D.
, 19 (Address) 2904 Park Ave

*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 Washington Park Cem DATE OF BURIAL March 18th 23

20. UNDERTAKER A. L. Beal ADDRESS 2726 Lucas

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

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.

