

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

Do not use this space.

13441

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City, Mo. (No. St Joseph 445)

Registration District No. 399
Primary Registration District No. 1002

File No. 1773
Registered No. 1773
St. _____ Ward _____

2. FULL NAME

Pearl Charles Robertson

(a) Residence. No. Health Bend, Mo. Ward _____
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 8 18

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

9. BIRTHPLACE (CITY OR TOWN) Summersville
(STATE OR COUNTRY) _____

10. NAME OF FATHER Eda Charles

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER Kate Richards

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

14. INFORMANT Albert G. Robertson
(Address) Health Bend Mo

15. FILED 4-19-28 M. M. Cron
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1928 to Apr 18 1928 that I last saw her alive on Apr 5 1928, and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock =
First symptoms 5 hrs after delivery
(duration) yrs. mos. ds.

CONTRIBUTORY Calumpnia =
(SECONDARY) (duration) yrs. mos. ds. 15

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? post mortem
(Signed) Wm. H. Hamilton M. D.
419, 1928 (Address) K.C. 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 Marshall Mo DATE OF BURIAL April 19 1928

20. UNDERTAKER John W. Wagner ADDRESS 1409 Grand Ave

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.

