

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

Do not use this space.

54292

1. PLACE OF DEATH
 County New Madrid Registration District No. 604
 Township " " " " Primary Registration District No. 3802
 City (No. _____) Sl. _____ Ward _____

2. FULL NAME Irma Aileen Roberts
 (a) Residence, No. Irma Aileen Pl. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-13-1928

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

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-27th 1928

17. I HEREBY CERTIFY, That I attended deceased from 10-10-1928, to 10-24th, 1928 that I last saw him alive on 10-24th, 1928, and that death occurred, on the date stated above, at 10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Enteritis latitans
1173/13 B
1186/13 B (duration) yrs. _____ mos. 20 ds.

CONTRIBUTORY Indigestion (SECONDARY) (duration) yrs. 1 mos. _____ ds.

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

10. NAME OF FATHER John Roberts

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

12. MAIDEN NAME OF MOTHER Pearl Smith

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

14. INFORMANT John Roberts (Address) New Madrid

15. FILED _____ 19 _____ REGISTRAR _____

18. WHERE WAS DISEASE CONTRACTED
8 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. D. Hake, M. D.
 (Address) New Madrid, 19 _____

*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 Evergreen Cem. DATE OF BURIAL _____ 19 _____

20. UNDERTAKER Richards Wnd. Co ADDRESS New Madrid

N.B. Information should be carefully supplied. AGE also to be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

... of the ...

... the ...

... of the ...

... of the ...

**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 New Madrid Registration District No. 604 File No.
 Township Primary Registration District No. 5802 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Iva Helen Roberts

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-13-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 14

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)

PARENTS

14. INFORMANT (Address)

15. FILED 12/5/29 Wissmann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 27 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at

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

10/29/1928

20. UNDERTAKER

ADDRESS

ACTLY. PHYSICIANS should fill out of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-34292