

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

Do not use this space.

MAY 2 5 7

1929

1. PLACE OF DEATH
County Saline Registration District No. 796
Township _____ Primary Registration District No. 3038
City Marshall (No. 512, No. Jefferson)
St. _____ Ward _____
Registered No. 13438
63

2. FULL NAME John Wathall Robertson
(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 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
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 Mary Ella Robertson
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 24, 1849
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 8 45 23
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Liverman
(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) Kentucky
10. NAME OF FATHER N. S. Robertson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Emily Thompson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia
14. INFORMANT This Deaf Robertson
(Address) 512 No. Jefferson
15. FILED 3-29-29 Mrs. John H. McQuinn
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24, 1929
17. I HEREBY CERTIFY, That I attended deceased from May 12, 1928, to March 24, 1929, that I last saw him alive on March 24, 1929, and that death occurred, on the date stated above, at 8:15 p. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
108
82D
CONTRIBUTORY (SECONDARY) Hemiplegia (duration) yrs. mos. ds. 4
(duration) yrs. mos. ds. 8
18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. H. Manning, M. D.
(Address) Marshall, 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 Ridge Park Cem DATE OF BURIAL Mar. 26, 1929
20. UNDERTAKER L. R. Vandiver ADDRESS Marshall, Mo

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.

PARENTS 2 2 2

