

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

Do not use this space.

13753

1. PLACE OF DEATH

County Andrew Registration District No. 26
City Mexico Mo Registration District No. 3002
Ward at Andrew Hospital File No. _____
Registered No. 53

2. FULL NAME

Essy Ray Roberts
(a) Residence. No. Route #2, Livingston Mo 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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) 4/15th 1909

7. AGE 19 YEARS 7 MONTHS 1 DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Living with parents
(b) General nature of industry, business, or establishment in which employed (or employer) House work
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Boone Co. Mo
(STATE OR COUNTRY)

10. NAME OF FATHER W. W. Roberts

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

12. MAIDEN NAME OF MOTHER Uta Sue Randall

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

14. INFORMANT W. W. Roberts, Father
(Address) Route #2, Livingston Mo

15. April 15th 1929 Ina S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-15-29 1929

17. I HEREBY CERTIFY That I attended deceased from 4-14-29 to 4-15-29, 1929
that I last saw him alive on 4-15-29 and that death occurred, on the date stated above, at PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular peritonitis
one Iu definal duration (duration) yrs. mos. da.
CONTRIBUTORY Strawberry ill for two
(SECONDARY) Weeks (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH His home
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4-15-29
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. H. Harrison M. D.
, 19 (Address) Mexico 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 Macedonia Church, county DATE OF BURIAL 4-16-29 1929

20. UNDERTAKER McPheters Bros - Mexico Mo.
ADDRESS

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.

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