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

399

Do not use this space. 2285

1. PLACE OF DEATH

County Jackson — Registration District No. 1002 — File No. 24873

Township Kaw — Primary Registration District No. — Registered No.

City Kansas City (No. 3027 Charlotte St. Ward)

2. FULL NAME Mrs. Agnes Carboy Robertson

(a) Residence. No. 3027 Charlotte St., 3 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. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	4	

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)
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Patrick Quinn

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

12. MAIDEN NAME OF MOTHER Isabell McGee

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

14. INFORMANT Mrs Blanche Batey
(Address) 3027 Charlotte

15. FILED 7/31, 1929 M. M. Crowe REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 28 1929

17. I HEREBY CERTIFY, That I attended deceased from about July, 1927 to July 28, 1929 that I last saw h. alive on July 28, 1929, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebrovascular with Paralysis
8971
09
11 48 C
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Pyelonephritis
(duration) yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at Place of Death
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Complete Paralysis
(Signed) J. J. Stephens, M. D.
July 30, 1929 (Address) 1114 E Armour

*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
St. Marys' Cemetery	7/31/29
20. UNDERTAKER	**ADDRESS**
Quirk & Tobin Co--20 W Linwood	

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.

2375

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be stated ... state CAUSE OF DEATH in plain terms, ... Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3285

City N. City (No. ....., ... St. ..... Ward)

2. FULL NAME Agnes Carbay 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 ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 .....
(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)

PARENTS
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)

14. INFORMANT .....
(Address)

15. FILED 1/31, 1929 M. M. Lerow REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 28 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis with paralysis of Right of X Face and Leg (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) Acute Indigestion Nausea and refused to Eat. About (duration) ...yrs. ...mos. 6 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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

See attached (over)

Wasserman Neg. Kahn Neg. - Blood Pressure.
Was about 100 - to 120 - Sys - about 180 to 250 -
No albumin - Sugar 2 to 3 X - Possibly
a little Condition -

S-24873