

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

Do not use this space.

25269

1. PLACE OF DEATH

County Mississippi
 Township St James
 Precinct East Prairie

Registration District No. 567
 Primary Registration District No. 6763

File No. _____
 Registered No. 42
 St. _____ Ward _____

2. FULL NAME Earley Roberson

(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 male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 2nd 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 9 4

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Farmer 1929
 (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) Osborne State of Miss

10. NAME OF FATHER Manah Roberson

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

12. MAIDEN NAME OF MOTHER Lizzie E. Riley

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

14. INFORMANT (Address) Lizzie Shelton East Prairie Mo

15. FILED July 29 1929 Cliff M. Hodger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS: -
was killed by being hit by head with something in the hands of some unknown person
 (duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) Murdered by some one
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1909
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

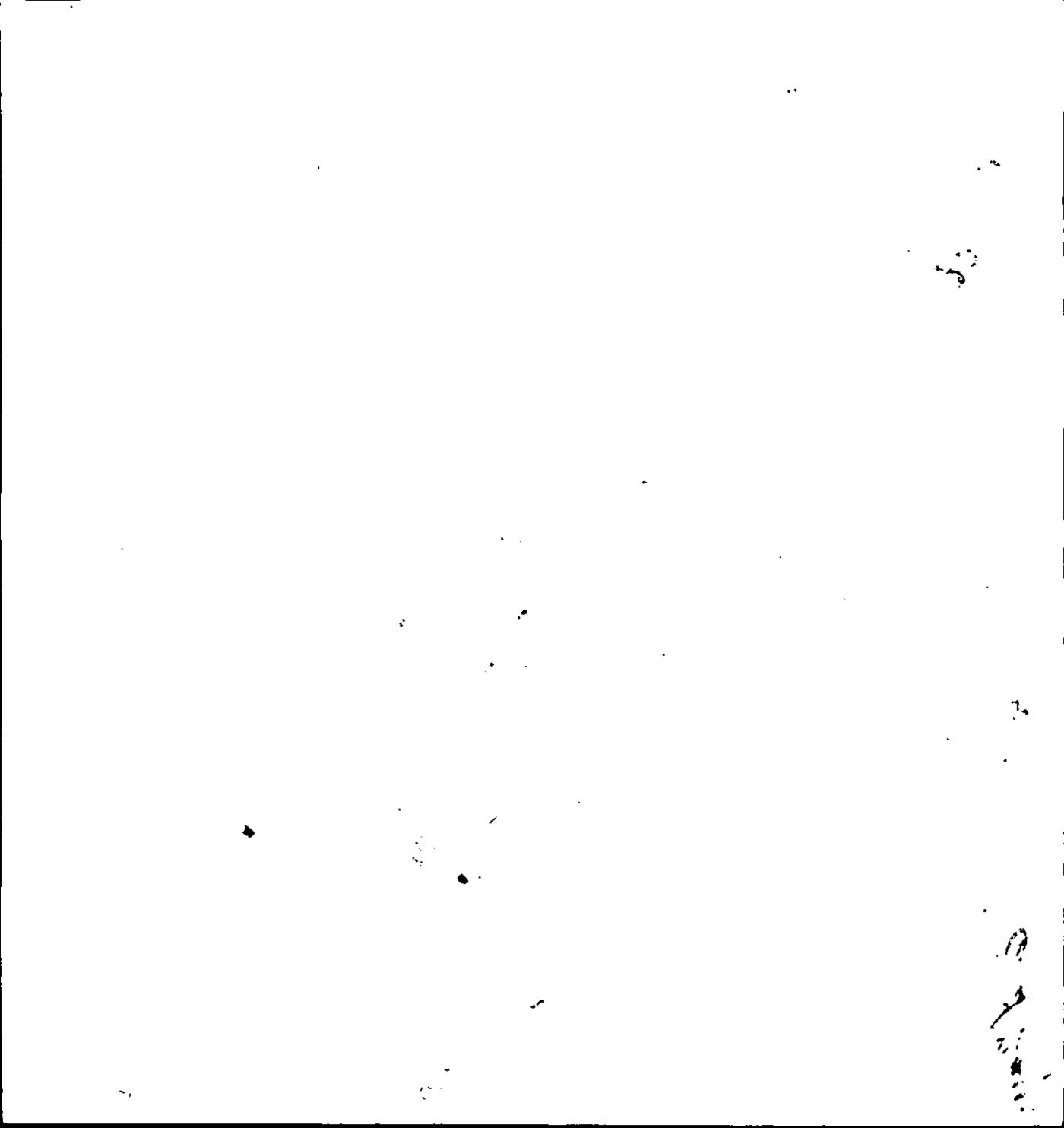
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Frank S. Vernon
 (Address) Charleston Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL (Address) Perthook cemetery DATE OF BURIAL July 7 1929

20. UNDERTAKER (Address) Travis Shelton East Prairie Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miss. Registration District No. 567 File No. _____
 Township St. James Primary Registration District No. 3-763 Registered No. 42
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Earley Robinson
 (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 M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED R
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 2 - 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
19 9 4

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 7-4-29 Druff M. Hodges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 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:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

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