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

Do not use this space.

34819

1. PLACE OF DEATH

County St. Charles — Registration District No. 757 — File No.

Township St. Charles — Primary Registration District No. 3036 — Registered No. 148

City St. Charles (No. ..... St. ..... Ward)

2. FULL NAME Rose Marie Roberson

(a) Residence. No. 1018 Locust St. St., 3rd Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred – yrs. 4 mos. 1 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	Colored	- - -

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12, 1929.

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

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) St. Charles, (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Abraham Roberson,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rockdale, (STATE OR COUNTRY) Texas.

12. MAIDEN NAME OF MOTHER Myrtle Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Shecotah, (STATE OR COUNTRY) Oklahoma.

14. INFORMANT Abraham Roberson
(Address) 1018 Locust St.

15. FILED 10/14, 1929 Hy. G. Bloebaum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 13 1929

17. I HEREBY CERTIFY, That I attended deceased from 10-10-29, 19..., to 10-13-, 1929 that I last saw her alive on 10-10-1929 and that death occurred, on the date stated above, at 7 45 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Diarrhea
11 4 13
15 18

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Uraemia?

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 1018 Locust

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) [signature], 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 Oak Grove Cemetery — DATE OF BURIAL Oct. 15, 1929.

20. UNDERTAKER Steinbrinker Furn. Co. — ADDRESS St. Charles.

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.