

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

Do not use this space.

38873

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **701**
Primary Registration District No. **1003**
(No. **1018 n 900**)

File No.
Registered No. **11317**
St. Ward)

2. FULL NAME *Robert Rogerson*

(a) Residence No. **1018 n 900** St. **25** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **9** yrs. **3** mos. **15** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>negro</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Maggie Rogerson</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>2. 2. 1864</i>		
7. AGE	YEARS <i>65</i>	MONTHS <i>9</i>
	DAY <i>13</i>	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *none*

(b) General nature of industry, business, or establishment in which employed (or employer). *labor*

(c) Name of employer. *none*

9. BIRTHPLACE (CITY OR TOWN) *Tenn*
(STATE OR COUNTRY) *Unknown*

10. NAME OF FATHER *John Rogerson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY) *Tenn*

12. MAIDEN NAME OF MOTHER *Cendis Smith*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY) *Tenn*

14. INFORMANT *Mrs Maggie Rogerson*
(Address) *1018 n 900*

15. FILED *19 1929*
Max C. Stanley REGISTER

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 15 1929*

17. I HEREBY CERTIFY That I attended deceased from *Nov 11 1929* to *Nov 15 1929* that I last saw him alive on *Nov 14 1929*, and that death occurred, on the date stated above, at *11:00* a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
198 Lobar Pneumonia
900
77

(duration) yrs. mos. ds.
CONTRIBUTORY *Chr myocarditis & arterio*
(SECONDARY) *Sclerosis indefinite*
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH DATE OF
WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *Thos. A. Lewis* M. D.
(Address) *2901 Market*

*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 *Delta Point Burial* DATE OF BURIAL *11. 30 1929*

20. UNDERTAKER *E. W. Reynolds* ADDRESS *3013 Bell Ave*

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.

237
2

