

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.

APR 28 1930

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

Do not use this space.

8442

1. PLACE OF DEATH

County Harrison  
Township Bethany  
City Bethany

Registration District No. 334  
Primary Registration District No. 4197

File No. 551  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

James M. Roberts

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-10-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
85 | 6 | 24

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Retired Merchant  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

10. NAME OF FATHER James Madison Roberts

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

12. MAIDEN NAME OF MOTHER Almariah Harrison

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

14. INFORMANT Elizabeth Roberts  
(Address) Bethany Mo

15. FILED 3/21, 1930 W J Harner  
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 4/30

17. I HEREBY CERTIFY, That I attended deceased from Mar 3rd, 1930, to Mar 4, 1930, that I last saw him alive on Mar 4, 1930, and that death occurred, on the date stated above, at 1 Pm m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Apoplexy

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) Arteriosclerosis, Chronic  
Interstitial nephritis, Indefinite

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS (Signed) D. G. Reid M.D.

3/4, 1930 (Address) Bethany 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 Miriam Cemetery DATE OF BURIAL 3-6 1930

20. UNDERTAKER S M Fess ADDRESS Bethany Mo

