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

Do not use this space.

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File No. 425

Registered No.

1. PLACE OF DEATH

County Buchanan Registration District No.

Township Primary Registration District No. 1001

City St. Joseph, Mo. (No. 615 Prospect St. Ward)

2. FULL NAME Infant Roberts

(a) Residence. No. 615 Prospect 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.

MAY 22 1930

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 6, 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	0	0	0	

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. Joseph
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Randolph W. Roberts

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Worth County
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Anna Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Worth County
(STATE OR COUNTRY) Missouri

14. INFORMANT Randolph Roberts
(Address) St. Joseph, Mo.

APR 9 1930

15. FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6, 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930, to Apr 6, 1930, that I last saw he alive on Apr 6, 1930, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature

1 hr

(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? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Frank Hartlegan M. D.

Apr 7, 1930 (Address) Krug Parman Bldg

*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
Memorial Park	April 7, 1930
20. UNDERTAKER	ADDRESS
Eleeman Funeral Home	1916 Calhoun

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Buchanan — Registration District No. 85 — File No. .....

Township ..... — Primary Registration District No. 1001 — Registered No. 425

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

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

PERSONAL AND STATISTICAL PARTICULARS

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

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 6-11, 1930 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 6 1930

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:

Premature

..... (duration) ..... yrs. ..... mos. 2 hrs. ..... ds.

CONTRIBUTORY (SECONDARY) 1610

..... (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) Marie Hartigan, M. D

, 19 (Address) Kirkpatrick Bldg

*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

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.

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

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