

JUN 4 1930

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

15340

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph, (No. Missouri Methodist Hospital St. _____ Ward)

2. FULL NAME Michael Wesley Roberts,
 (a) Residence. No. _____ St. _____ Ward. Westboro, Missouri,
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5th. 1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
76 10 27

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

9. BIRTHPLACE (CITY OR TOWN) Westboro,
 (STATE OR COUNTRY) Missouri,

10. NAME OF FATHER James Roberts,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
 (STATE OR COUNTRY) Indiana,

12. MAIDEN NAME OF MOTHER Elizabeth Kime,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
 (STATE OR COUNTRY) North Carolina

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2, 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr 23 1930, to May 2 1930 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 2:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
137
132B

CONTRIBUTORY (SECONDARY) Hypertrophy of prostate (duration) yrs. mos. ds. 4
Special (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Westboro, Mo.
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Apr. 25
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Operation & clinical
 (Signed) Wm. Caryl Porter, M. D.
May 2, 1930 (Address) 731 Taram

*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 Westboro, Missouri Auto DATE OF BURIAL May 4th. 1930.

20. UNDERTAKER Shearon - O'Connell - Bowman ADDRESS 319 S. 10 St.
Funeral Home

14. INFORMANT Guy P. Roberts
 (Address) Westboro, Missouri.

15. FILED 2 1930
John G. [Signature] REGISTRAR

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS 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

1. PLACE OF DEATH.

County Duch Registration District No. 83 File No.
 Township Primary Registration District No. 1001 Registered No. 339
 City St Joseph (No.) St. Ward)

2. FULL NAME

Michael Wesley 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) Wid
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5 - 1852
 7. AGE YEARS 77 MONTHS 10 DAYS 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. da.
 (c) Name of employer

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

10. NAME OF FATHER

PARENTS

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 7/2/30 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2 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:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.
 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

011851-5