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

Do not use this space.

13295

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File No. .....

Registered No. 462

1. PLACE OF DEATH

County Buchanan — Registration District No. .....

Township .....

City St Joseph (No. 121 Michell St. .....Ward) — Primary Registration District No. 1001

2. FULL NAME John Roberson

(a) Residence. No. 121 Michell 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.

11
5
1

MAY 2 1 1931

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ~~Ida Roberson~~ Divorced

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13 - 1903

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
28.	3	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Car Washer

(b) General nature of industry, business, or establishment in which employed (or employer) Car Washer

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Joseph
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Patrick Roberson

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

12. MAIDEN NAME OF MOTHER Mary Roberson

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

14. INFORMANT Mary McHanner
(Address) 8176 N 2nd St

APR 29 1931
FILED ....., 19..... John A. Bender
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 25 1931

17. I HEREBY CERTIFY, That I attended deceased from January, 1931, to April 25, 1931, that I last saw h alive on April 25, 1931, and that death occurred, on the date stated above, at 8 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
T.B.
T.B.
(duration) ..... yrs. 3 mos. 9 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ..... yrs. 3 mos. 9 ds.

18. WHERE WAS DISEASE CONTRACTED Do not Know

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Observation Sputum Test

(Signed) J. R. Crossland M.D.

4-29-1931 (Address) 720 S 4th St

*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
City Cemetery	April 29 1931
20. UNDERTAKER	**ADDRESS**
Ramsey Funeral Service	9th & Olive

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD