

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

Do not use this space.

2173

FFB 25 1932

1. PLACE OF DEATH

County St. Francois
Township St. Francois
Near City Farmington, Mo. (No. 4)

Registration District No. 773
Primary Registration District No. 2464

File No. _____
Registered No. 6
St. _____ Ward _____

2. FULL NAME Frank Roberts

(a) Residence, No. St. Louis 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13, 1932

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

22. I HEREBY CERTIFY, That I attended deceased from 10-24, 1931, to 1-13, 1932

I last saw him alive on 1-13, 1932 Death is said to have occurred on the date stated above, at 10:30 a. m. The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown ? ?
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 63 ? 00

Bilateral lobar pneumonia
Date of onset 1-11-32

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Plumbing
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: Generalized arterio sclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT (ADDRESS) Hospital Records Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hospital Cemetery date 1-15, 1932

19. UNDERTAKER (ADDRESS) Hospital Farmington Mo

20. FILED Jan 18, 1932 J. Robinson Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) Fred Korte, M. D. (Address) Farmington Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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