

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

Do not use this space.

13700

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

1. PLACE OF DEATH

9^{1/2} County St. Louis Registration District No. 1005-
Township E. Doyle Primary Registration District No. 6009
City _____ (No. _____) _____

2. FULL NAME

Joseph Roberts
(a) Residence No. Usta Mo 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE <u>Unknown</u>	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

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

PARENTS	10. NAME OF FATHER <u>unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	12. MAIDEN NAME OF MOTHER <u>unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT Mrs. Marian Roberts
(Address) Collins Mo R.F.D.

15. FILED May 10 1932 Minnie H. Gordon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) April 14 1932
17. I HEREBY CERTIFY, That I attended deceased from March 8 1932 to April 14 1932
that I last saw him alive on April 4 1932, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Influenza complication of Double Pneumonia "Bunch" with general debility & age
112 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Bunchal Pneumonia
107A (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? Smear
(Signed) C. D. Sullivan, M. D.
, 19 _____ (Address) Osceola 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 Robert's Cemetery DATE OF BURIAL Apr 15 1932

20. UNDERTAKER O. S. Hull ADDRESS Osceola Mo.

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.

MAY 28 1932

WHITE PAPER, WITH CARBONS BACK—THIS IS A PERMANENT RECORD

