

AUG 27 1937

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

Do not use this space.

## 1. PLACE OF DEATH

County PeniscotRegistration District No. 653Township BraggodociaPrimary Registration District No. 5871City Hayti

(No. ....)

St. ....

Ward) .....

2. FULL NAME Hubert Robertson

(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 1 yrs. 9 mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Male

## 4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED, OR  
DIVORCED (write the word)  
Married5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OFCallie Robertson

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

## 7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, ..... hrs.  
or ..... min.

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as spinner,  
sawyer, bookkeeper, etc.Farmer9. 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  
occupation12. BIRTHPLACE (CITY OR TOWN).  
(STATE OR COUNTRY)Jackson  
Tenn

## 13. NAME

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

## 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN).  
(STATE OR COUNTRY)17. INFORMANT  
(ADDRESS)J. H. Jones  
Steele, Mo. R.F.D. 218. BURIAL, CREMATION, OR REMOVAL  
PLACEMt ZionDATE May 16th 193719. UNDERTAKER  
(ADDRESS)German Undt. Co  
Steele, Mo.

## 20. FILED

19.....

Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15th 193722. I HEREBY CERTIFY That I attended deceased from  
May 15 to May 15I last saw him alive on May 10 1937 Death is said  
to have occurred on the date stated above, at 4: A.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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) J. H. Jones, M. D.(Address) Steele, Mo.

WHITENING INK---THIS IS A PERMANENT RECORD

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.

FORM 22-30  
I X 2314

[The main body of the document is extremely faint and illegible. It appears to contain several paragraphs of text, but the characters are too light to be transcribed accurately. There are some faint markings and lines that suggest a structured document, possibly a report or a letter.]

[The lower portion of the document is also illegible due to fading. It contains what appears to be a signature block and possibly a date or reference number, but the text is not discernible.]

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

28017  
Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 653  
(b) Township Braydoe Primary Registration District No. 5871 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hubert Robertson

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Callie Robertson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 12 - 1890  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 47 1 3  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Tennessee

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) J. H. Jones Steel Bros R.F.D 3

18. BURIAL, CREMATION, OR REMOVAL PLACE mt Zion DATE May 16 1937

19. FUNERAL DIRECTOR (ADDRESS) German mill Co Steel

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15 1937

22. I HEREBY CERTIFY, That I attended deceased from mech 15 1936 to May 15 1937

I last saw him alive on May 10 1937. Death is said to have occurred on the date stated above, at 4 A. M.  
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) Dred L. Ogilvie, M. D.

(Address) Carnitherville 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.

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

RECEIVED

S-28017