

1939 MAY 18 1939

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

Do not use this space.

15311

1. PLACE OF DEATH
County Madison
Township Freedom
City 163 Millard St. Robert

Registration District No. 457
Primary Registration District No. 47021B

File No. _____
Registered No. 19
St. _____ Ward _____

2. FULL NAME Millard W. 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. 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) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucinda Jane Roberts
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 31 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 8 17

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Printer
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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnson Co Mo

13. NAME John Roberts

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

15. MAIDEN NAME Mary Pettit

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Lucinda Jane Roberts

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Grove DATE 4-19 1939

19. UNDERTAKER (ADDRESS) Asst. Dr. ...

20. FILED April 19 1939 Registrar W. ...

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-17-1939

22. I HEREBY CERTIFY, That I attended deceased from 4-17-1939 to 4-17-1939
I last saw him alive on 4-10-1939 Death is said to have occurred on the date stated above, at 2:15 P.M.
The principal cause of death and related causes of importance were as follows:

Chr. Myocarditis Date of onset ?

Other contributory causes of importance: 93

Name of operation _____ Date of _____
What test confirmed diagnosis? physical Was there an autopsy? no

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? no
If so, specify _____

(Signed) R. F. ... M. D.
(Address) W. ...

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5/31/39