

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 21 1947
Registration District No. 392

Primary Registration District No. 5549

Registrar's No. 2

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Howard

(b) City or town Roanoke Prairie (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether)

In this community All his life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45

(c) City or town Roanoke 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. X (If rural, give location) 0

(e) Citizen of foreign country? X (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME John Wesley Robertson

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Yes

6. (b) Name of husband or wife Katie Finnell Robertson

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased: Nov. 3, 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

85 3 4 hr. min.

9. Birthplace: Roanoke Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming (Retired)

11. Industry or business X

MOTHER FATHER

12. Name Andrew Jackson Robertson

13. Birthplace Roanoke Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Carolyn Davis

15. Birthplace Philadelphia Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William Robertson

(b) Address Roanoke, Mo.

17. (a) Burial (b) Date thereof 2-8-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roanoke Cemetery

18. (a) Signature of funeral director Mary Oldaker

(b) Address Armstrong, Mo.

19. (a) 2-11-47 (b) Joe May
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 6th
year 1947 hour 6:30 minute 9 M.

21. I hereby certify that I attended the deceased from 125 to 1987
in Feb 5th 1947

that I last saw h^e alive on Feb 5th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis
Chronic Cerebral Arteriosclerosis

Due to.....

Due to.....

Other conditions Chronic Bronchitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

(Specify type of place)
While at work?..... (c) Means of injury.....

23. Signature W. M. Dickerson (M. D.)
Address Armstrong, Mo. Date signed 2/8/47

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4-18-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Mary Oldaker

Licensed Embalmer No. 3399

P. O. Address Armstrong, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.