

SEP 21 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Monteair*
Township *Waller*
City _____ (No. _____) St. _____ Ward _____

Registration District No. *571*
Primary Registration District No. *5769*

File No. *31265*
Registered No. *99*

2. FULL NAME

Washington Roberts
(a) Residence, No. *Small of County Home* Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS *78* MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

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

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) *St. Clair Co. Missouri*

13. NAME *Benjamin Roberts*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Clair Co., Mo.*

15. MAIDEN NAME *Do not know*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*

17. INFORMANT (ADDRESS) *Mrs. Don Leggs California, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Old Farm Cemetery* DATE *8-11* 19*37*

19. UNDERTAKER (ADDRESS) *W. Wilson & Son California, Mo.*

20. FILED *8-11-37* *H.R. Popejoy Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-9-1937*

22. I HEREBY CERTIFY, That I attended deceased from *4-2-1937* to *8-9-1937*

I last saw him alive on *6-6-1937*. Death is said to have occurred on the date stated above, at _____ m.

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

Arteriosclerosis

Date of onset

Other contributory causes of importance:

Senility + blind caused by age

Name of operation *none* Date of _____

What test confirmed diagnosis? *Clinical* 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 *1*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *H.P. Popejoy*, M. D.

(Address) *California 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.

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571
5769

OCCUPATION

FATHER

MOTHER

