

COMMONWEALTH OF KENTUCKY
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH Paducah File No. 5711
 Hospital No. 1311 Registered No. 84
 Year Reported 1935
 Hospital No. 1311 Name of Hospital Logan Hospital, Paducah, Ky.

FULL NAME Robert Lee Roberts Sex M Age 36 Race W
 Residence No. 144 City Paducah State Ky. Date of Birth April 29, 1896
 Occupation Fireman

PERSONAL AND STATISTICAL PARTICULARS

1. SEX M 2. COLOR OF SKIN W 3. EYES Blue 4. HAIR Black
 5. BUILD Slender 6. STATE OF BIRTH Ky. 7. MARRIAGE Married
 8. OCCUPATION Fireman

9. BIRTHPLACE Paducah, Ky.
 10. MARRIAGE John W. Roberts
 11. BIRTHPLACE Kentucky
 12. MARRIAGE Hattie Hays
 13. BIRTHPLACE Ky.
 14. BIRTHPLACE John W. Roberts
 15. BIRTHPLACE Christiansburg, Va.
 16. NAME, ADDRESS OF DECEASED John W. Roberts, 144
 17. NAME, ADDRESS OF DECEASED John W. Roberts, 144
 18. NAME, ADDRESS OF DECEASED John W. Roberts, 144

MEDICAL CERTIFICATE OF DEATH

19. DATE OF DEATH Dec. 6, 1935
 20. I HEREBY CERTIFY THAT I attended deceased since Nov. 20, 1935 to Dec. 6, 1935
 21. I have examined the body and find that death is due to Pulmonary Edema
Complicated by
Coronary Atherosclerosis
and
Myocardial Infarction
 22. I believe the cause of death to be Pulmonary Edema
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MAJOR INSTRUCTIONS: THIS FORM IS TO BE FILLED BY A PHYSICIAN OR OTHER PERSON WHO HAS BEEN TRAINED IN THE USE OF THIS FORM. IT IS NOT TO BE FILLED BY A CLERK OR OTHER PERSON WHO HAS NOT BEEN TRAINED IN THE USE OF THIS FORM. THE DECEASED SHOULD BE IDENTIFIED BY NAME, ADDRESS, AND CITY AND STATE. THE CAUSE OF DEATH SHOULD BE STATED IN FULL, INCLUDING THE DISEASE OR INJURY AND THE RESULTING CONDITION. THE DATE OF DEATH SHOULD BE STATED IN FULL. THE SEX, COLOR, BUILD, HAIR, EYES, AND MARRIAGE SHOULD BE STATED. THE OCCUPATION SHOULD BE STATED. THE BIRTHPLACE SHOULD BE STATED. THE NAME, ADDRESS, AND CITY AND STATE OF THE DECEASED SHOULD BE STATED. THE NAME, ADDRESS, AND CITY AND STATE OF THE DECEASED SHOULD BE STATED. THE NAME, ADDRESS, AND CITY AND STATE OF THE DECEASED SHOULD BE STATED.