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

Do not use this space.

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1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. In Ambulance enroute to Hospital St. ..... Ward)

File No.....

Registered No. 2481

2. FULL NAME Sadie M. Roberts

(a) Residence. No. 1813 Ohio ave. St., 23 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Negro	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8 1894

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
32	8		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Edward Roberts

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Sarah Wilkerson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT Charles Roberts
(Address) 1813 Ohio ave.

15. MAR 12 1927 Max C. Starcoff
FILED 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/9 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

5/18 Intra-Uterine Haemorrhage
1 yr. W. M. A.
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fibroid Non Malignant
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? Yes?
WHAT TEST CONFIRMED DIAGNOSIS?

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(Signed) H. D. Fath M.D.
3/10, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood — DATE OF BURIAL 3/12 1927

20. UNDERTAKER A. Russell Und. Co. — ADDRESS 2732 Pine Blvd.

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.