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

Do not use this space.

12540

791

1003

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 3064

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Emily Roberts

(a) Residence. No. 1313 N. 9th St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 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	Col.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1 1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	51	3	26	

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

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Gabel McCleary

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

12. MAIDEN NAME OF MOTHER Victoria Unknown

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

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED MAR 11 1929, 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7- 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-7- 1929, to 3-7- 1929 that I last saw her alive on 3-7- 1929, and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. myocarditis
920
1
908 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) T. E. Cunningham M.D.
, 19 (Address) 2945 Lawton

*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	DATE OF BURIAL
Greenwood Cemetery	3/14 1929
20. UNDERTAKER	**ADDRESS**
R. M. C. Green	3517 Laclede ave

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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