

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.

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

16591  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City St. Louis Mo. (d) Street No. Christian Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Mrs. Julia A. Robertson

(a) Residence, No. 4409 Randa ll Place St. 9  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 27-1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	84	2	17	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Housework  
 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) Germany

FATHER 13. NAME Chas. Heuc kroth

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Frank Hagensicker  
 (ADDRESS) 4409 Randall Place

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Mt. Lebanon DATE May 16-38 19..

19. FUNERAL DIRECTOR (NAME) Henry Leiden U. Co.  
 (ADDRESS) 1417 N. Market St

20. FILED MAY 15 1938 J. F. Brudick  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Ma y 14-38 19..

22. I HEREBY CERTIFY, That I attended deceased from 5-11-38, 19.. to 5-14-38, 19..

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 5:15 a.m.  
 The principal cause of death and related causes of importance were as follows:

Left hemiplegia  
caused by cerebral  
hemorrhage  
of 20  
 Other contributory causes of importance:  
Arterial hypertension  
General arteriosclerosis

Date of onset 5-11-38

Name of operation..... Date of.....  
 What test confirmed diagnosis? Exam Was there an autopsy? no

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.....

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify.....  
 (Signed) Holliman M. D.  
 (Address) 507 E. Main St

**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

*John P. Buckholz*

Licensed Embalmer No. 1674

P. O. Address .....

**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, above space should be left blank.**

Dr. H. H. ... - 5074 ...