

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.

1939 MAY 10 1938

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

12870
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 791
 (b) Township St. Louis Primary Registration District No. 1003
 (c) City St. Louis (d) Street No. BARNES HOSPITAL
 (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.

Registered No. 3212

2. PRINT FULL NAME

(a) Residence, No. 5557 Cates St. 5
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 6, 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 3 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 1 yr. ago
 11. Total time (years) spent in this occupation 15 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hazen, Arkansas

13. NAME James Fuller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Alabama

15. MAIDEN NAME Sarah Sanders

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Georgia

17. INFORMANT (ADDRESS) Mr. Jack Fuller, 513 North Spring Ave.,

18. BURIAL, CREMATION, OR REMOVAL PLACE LAKE CHARLES DATE 4-8-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe Inc., 4700 Washington Blvd

20. FILED APR 5 1939 J. D. Bishop Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-5-39

22. I HEREBY CERTIFY, That I attended deceased from 4-4-39 to 4-5-39

I last saw h. c. alive on 4-5-39, 1939 Death is said to have occurred on the date stated above, at 9:15 a.m.

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

Headache disease Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury

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?

If so, specify (Signed) FR Bradley M. D.

(Address) BARNES HOSPITAL

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.....

J. G. Sullivan

Licensed Embalmer No. *1122*

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.