

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.

REC'D JUL 12 1939

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

20358

Do not use this space.

5202

791

1008

## 1. PLACE OF DEATH

- (a) County..... 2 Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City St. Louis Mo. (d) Street No. 5223 Tholozan. 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 <sup>16.3</sup> Annie O. Robertson.

- (a) Residence, No. 5223# Tholozan St. 14  
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 8th, 1855.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
83 1D 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. H'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)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland. 413. NAME John Calderwood 414. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland. 415. MAIDEN NAME Annie Wyhe16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland.17. INFORMANT (ADDRESS) Janet Finley  
5223 Tholozan.18. BURIAL, CREMATION, OR REMOVAL PLACE Sunset Hill Cem. DATE 6/10/39.19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe Inc.  
4700 Washington Blvd20. FILED JUN 9 1939  
J. F. Bredich  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/7/39 19I HEREBY CERTIFY, That I attended deceased from 6/4/39, 19, to 6/7/39, 19.I last saw h. e. alive on 6/6/39, 19. Death is said to have occurred on the date stated above, at 13<sup>30</sup> a.m.

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

Coronary Thrombosis Date of onset 6/1/39

Other contributory causes of importance:

Chronic Myocarditis

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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?.....

If so, specify Dr. Oscar Sawyer M. D.(Signed) J. F. Bredich (Address) 916 No. Tholozan Bldg.

**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 Guy W. Wilkinson

Licensed Embalmer No. 3575

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.**