DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 14 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27525

Registration District No. 791 Primary Registration District No. _____ Registrar's No. 7025

1. PLACE OF DEATH: 1008

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Enroute to Homer Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")

(d) Street No. 3402a Laclede Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

No attending physician

3. (a) PRINT FULL NAME Miles Roberts 163

3. (b) If veteran, name war no

3. (c) Social Security No. nil

4. Sex M

5. Color or race C

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May (Month) 15, (Day) 1862 (Year)

8. AGE: Years	Months	Days	If less than one day
77	2	24	_____ hr. _____ min.

9. Birthplace Mississippi (City, town, or county) _____ (State or foreign country)

10. Usual occupation Laborer (Unemployed)

11. Industry or business _____

FATHER
12. Name Oliver Roberts
13. Birthplace Mississippi (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Francis (Unk)
15. Birthplace Mississippi (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Sumbler Roberts
(b) Address 3402a Laclede Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/39 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director [signature]
(b) Address 3517 Laclede Ave.

19. (a) AUG 13 1939 (Date received local registrar) (b) J. T. Bordash (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 9 year 1939 hour 3 minute 8 M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__;
that I last saw h_____ alive on _____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Hypertension

Due to [illegible]

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Joseph M. [illegible] (M. D. or other)
Address Deputy Coroner Date signed 8-8-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 I X19511

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 R. M. McGheen

Licensed Embalmer No. 1173

P. O. Address 3517 Saclede Ave

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.