

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27577
7077

State File No.

Registrar's No.

791
1008
SEP 14 1939

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Mo. Baptist Hospital
(d) Length of stay: In hospital or institution 7-days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(d) Street No. Westmoreland Hotel
4496 Westmoreland Ave
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME Charles V. Roberts 163

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Julia M. Roberts 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Mar. 22 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 4 21 hr. min.

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

10. Usual occupation Broker

11. Industry or business Investment

12. Name Frank Roberts

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Wilson
(City, town, or county) (State or foreign country)

15. Birthplace Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia M. Roberts

(b) Address 4405 W. Pine Blvd.

17. (a) Burial (b) Date thereof 8-16-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) AUG 15 1939 (b) J. J. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13
year 1939 hour 8 minute 55 a. M.

21. I hereby certify that I attended the deceased from Aug 8, 1939 to Aug 13, 1939
that I last saw him alive on Aug 13, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death acute myocardial infarction Duration 1 day

Due to _____
Due to _____

Other conditions exacerbation of 3 mos.
(Include pregnancy within 3 months of death)
diabetes

Major findings: _____
Of operations _____
Of autopsy above

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Delany (M. D. or other) _____
Address 508 N. Grand Date signed 8/15/39

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 W H Van Mater

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

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.