No. 2
-10-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33212

CT 10 1940

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1744

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

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Admitted 9/6/40 (Specify whether
In this community unknown.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 4068-A Cook Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Fred Roberts

3. (b) If veteran, name war World War

3. (c) Social Security No. Yes "Not Remembered"

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Pearl

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

7. Birth date of deceased March (Month) 1. (Day) 1888 (Year)

8. AGE: Years 52 Months 6 Days 12 If less than one day hr. min.

9. Birthplace East St. Louis (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Odd Jobs

11. Industry or business -

FATHER
12. Name John Roberts
13. Birthplace (City, town, or county) Alabama (State or foreign country)

MOTHER
14. Maiden name Adelia Glasby
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant M. Schilling
(b) Address Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) E. Washington (Burial, cremation, or removal) (b) Date thereof 9-18-40 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis Ill

18. (a) Signature of funeral director [signature]
(b) Address 5517 Lockade Ave

19. (a) SEP 14 1940 (Date received local registrar) (b) R. Meyer [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13th year 1940 hour 1:00 minute a.M.

21. I hereby certify that I attended the deceased from Sept. 6, 1940 to Sept. 13, 1940; that I last saw him alive on Sept. 13, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease, with cardiac enlargement, myocardial damage and

Due to myocardial insufficiency. unkn.

Due to -

Other conditions Arteriosclerosis, general, with cerebral involvement and motor aphasia.
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operations.
Of autopsy No 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) no
(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 C. W. HUGHES, M.D. (M. D. or other)
Address Chief Medical Officer Date signed 9/13/40

(Licensed Embalmer's Statement on Reverse Side)

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. Green

Licensed Embalmer No. 1173

P. O. Address 3517 Laclede Av

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.