

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5421<sup>st</sup> Gravois  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 4 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5421<sup>st</sup> Gravois 29  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 12  
year 1941 hour 4 minute 15 M.  
21. I hereby certify that I attended the deceased from 7<sup>th</sup> Feb.  
1941 to June 12, 1941  
that I last saw him alive on June 11<sup>th</sup> 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Gastric hemorrhage Duration 2 da  
Due to Carcinoma of stomach  
Jamoked 1 day  
Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)  
Major findings: no  
Of operations no  
Of autopsy no  
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 B. J. Shaukin (M. D. or other)  
Address 1374 S. Jefferson Date signed 6/12/41

3. (a) PRINT FULL NAME CHARLES M. ROBERTS

3. (b) If veteran, name war No 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ruth Roberts 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased June 22, 1893 (Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Maintenance man

11. Industry or business St. Louis City Hospital

12. Name Charles Roberts

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

14. Maiden name Frances Fontaine

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

16. (a) Informant Mrs. Marion Lincoln

(b) Address 300<sup>th</sup> Broadway, St. Louis, Mo.

17. (a) Burial (b) Date thereof 6-14-41 (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo.

18. (a) Signature of funeral director James Broder

(b) Address Centralia, Mo.

19. (a) JUN 23 1941 (Date received local registrar) (b) J. W. Bredek (Registrar's signature)

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

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**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

*Gustav R. Baumann*

Licensed Embalmer No. *2315*

P. O. Address *Overland, Mo*

**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, fact should be so stated above.**