

FILED JUL 8 1943 318

Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (b) City or town St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. John's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 days
 In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 004
 (c) City or town St. Louis (If outside city or town limits, write "RURAL")
 (d) Street No. 3161a Oregon Avenue (If rural, give location)
 (e) Citizen of foreign country? -- (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Theodore L. Roberson

3. (b) If veteran, name war No

3. (c) Social Security No. 490-12-4315

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

6. (b) Name of husband or wife Irma Roberson
 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased October 20, 1900
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 8 6 _____ hr. _____ min.

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

10. Usual occupation Internal Sec. Division

11. Industry or business Federal Medical Dept.

MOTHER FATHER
 12. Name Frank Roberson
 13. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Irma Roberson
 (b) Address 3161a Oregon Ave.

17. (a) Burial (b) Date thereof 6 30 43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Wacker-Heldreth Und. Co.
 (b) Address 3634 Gravois Avenue

19. (a) 5/14 210 (b) J. P. Brudick
 (Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
 year 1943 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 10 1943, to June 26 1943
 that I last saw him alive on June 24 1943 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Displaced Appendix
General Peritonitis

Due to Complications

Due to _____

Other conditions (Include pregnancy within 3 months of death) 12/11

Major findings: Of operations _____

Of autopsy yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature J. A. O'Brien M.D. (M. D. or other)
 Address 208-1657 So. Grand Blvd Date signed 6-18-43

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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..... *Frank J. D'Amico*
Licensed Embalmer No..... *96-15*
P. O. Address..... *St Louis 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.