

FILED OCT 22 1943

State File No.

Registration District No. **318**

Primary Registration District No.

Registrar's No.

**9017**

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:  
Missouri Pacific 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 years, months or days)

3. (a) PRINT FULL NAME RISE CASHMERE ROBERTS

3. (b) If veteran, name war \_\_\_\_\_ 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 Alma L. Roberts 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased December 11, 1894  
(Month) (Day) (Year)

8. AGE: Years 48 Months 9 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Switchman

11. Industry or business Railroad

12. Name Jefferson D. Roberts

13. Birthplace Don't Know 7  
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Poole

15. Birthplace Don't Know 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alma Roberts  
(b) Address 3610 McDonald

17. (a) Burial (b) Date thereof Oct. 13, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cemetery

18. (a) Signature of funeral director Weick Brothers Und.  
(b) Address 2201 S. Grand Bl.

19. (a) OCT 13 1943 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

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. 3610 McDonald Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 9  
year 1943 hour 1 minute 25 P.M.

21. I hereby certify that I attended the deceased from JUNE 23 1943 to OCTOBER 23 1943

that I last saw him alive on OCTOBER 8 1943 and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS 6 MOS

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions AXILLARY NEURITIS 4 MOS  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 0

23. Signature Gilbert H. Wright (M. D. or other) \_\_\_\_\_  
Address Mo. Pac. Hosp. Date signed 10-9-43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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..... *Wang A. Stewart* .....

Licensed Embalmer No..... **3722** .....

P. O. Address..... **412 Duchouquette St.** .....

**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.**