S. No. 2
M—2-43
5-17-39
I. X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 9 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

4182

State File No.

Registration District No. 316 Primary Registration District No. 306-1 Registrar's No. 91

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town St Francois Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: (Not Inc) Esther Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 26
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Francois 94
(c) City or town Esther
(If outside city or town limits, write "RURAL")
(d) Street No. Missouri
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert L. Roberts
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 17 (Day) 1872 (Year)

8. AGE: Years 71 Months 2 Days 19 If less than one day hr. min.

9. Birthplace Patton Mo (City, town, or county) Bolinger Co (State or foreign country)
10. Usual occupation
11. Industry or business Retired Minor
FATHER
12. Name Tom Roberts
13. Birthplace Sedrick Mo (City, town, or county) Bolinger Co (State or foreign country)
MOTHER
14. Maiden name Dont Know
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Lelia Roberts
(b) Address Flat River Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Park View
18. (a) Signature of funeral director Sparks Und Co.
(b) Address Flat River Mo
19. (a) Jan. 8-1944 (Date received local registrar) (b) Byrdie Buhrmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day January year 44 hour 2 Pm minute M.
21. I hereby certify that I attended the deceased from Jan 2, 1944 to Jan 5, 1944 that I last saw him alive on Jan 5, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	2 day
Due to	
Due to Influenza	5 day
Other conditions old age (Include pregnancy within 3 months of death)	
Major findings: Of operations 33a	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature F W Zuspan (M. D. or other) DO
Address Flat River Mo Date signed 1/7/44

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 4

District File Number 244-3291

Date Filed 2-5-44

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 Everett Sharp

Licensed Embalmer No. 4287

P. O. Address Flat River 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.