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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 28 1944

Registration District No. 3497

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 8374

Registrar's No. 475

**1. PLACE OF DEATH:**

(a) County St Louis

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

(c) Name of hospital or institution: Robert Koch Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr, 2 mo, 7 days (Specify whether
In this community 20 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 000

(a) State Missouri (b) County — 12

(c) City or town St Louis 5
(If outside city or town limits, write "RURAL")

(d) Street No. 2810 a N. Nuastead
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME ROBERTS, CLIFTON

3. (b) If veteran, name war

3. (c) Social Security No. 496-18-4679

4. Sex M

5. Color or race C

6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife Marcella Roberts

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

7. Birth date of deceased Oct (Month) 11 (Day) 1922 (Year)

8. AGE: Years 21 Months 4 Days 7 If less than one day ___ hr. ___ min.

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

10. Usual occupation maintenance man

11. Industry or business

FATHER
12. Name Clifton Roberts
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Florence Unknown.
15. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

16. (a) Informant Hospital Record
(b) Address Robt Koch Hosp

17. (a) E. St Louis Ill (Burial, cremation or removal) (b) Date thereof 2/23/44 (Month) (Day) (Year)
Removal
(c) Place: burial or cremation E. St Louis Ill

18. (a) Signature of funeral director [illegible]
(b) Address 3517 Sackdale Ave

19. (a) FEB 24 1944 (Date received local registrar) (b) E. G. McGavran, M.D. (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 18
year 1944 hour 4 minute 05 A M.

21. I hereby certify that I attended the deceased from Dec 11, 1942, to Feb 18, 1944;
that I last saw him alive on Feb 18, 1944;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pulmonary Tuberculosis | 17 mo |
| Due to | |
| Due to | |
| Other conditions: Tuberculous Peritonitis (Include pregnancy within 3 months of death) | 1 wk |
| T. B. of intestines 8 mo | |

Major findings:
Of operations
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 0

23. Signature Frank Cohen (M. D. or ~~other~~)
Address Robt Koch Hosp Date signed 2/18/44

(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 D. M. Green

Licensed Embalmer No. 1173

P. O.-Address 3517 Laclede Ave

**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.**