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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 26 1944

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 3520

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

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:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME DORIS JEAN ROBERTS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 16 years

7. Birth date of deceased August 16 1926
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>17</u>	<u>7</u>	<u>26</u>	hr. min.

9. Birthplace Aubudon Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business

12. Name Glenn Roberts

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

14. Maiden name Leola McCain

15. Birthplace Bismarck North Dakota
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Glenn Roberts

(b) Address Des Moines, Iowa

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof 4-13-44
(Month) (Day) (Year)

(c) Place: burial or cremation Audubon, Iowa

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) APR 17 1944 (Date received local registrar)

J. F. Bedeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Polk

(c) City or town Des Moines
(If outside city or town limits, write "RURAL")

(d) Street No. 850 8th St.
(If rural, give location)

(e) Citizen of foreign country? 2 0
(Yes or No)

If yes, name country 2 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1944 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from March 29, 1944, to April 12, 1944

that I last saw h. alive on _____, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Advanced Tubercular
Culosis of lungs

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations as above

Of autopsy as above

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 M. C. Abney (M. D. or other) _____

Address BARNES HOSPITAL Date signed 4/12/44

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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

Albert A. Kopp

Licensed Embalmer No. 1865

P. O. Address.....

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.