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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19154

FILED JUN 19 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4947

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: De Paul 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 5914 Bermuda Dr. NR
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Ray S. Roberts

3. (b) If veteran, name war 2nd. World War

3. (c) Social Security No.

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 3rd. (Day) 1922 (Year)

8. AGE: Years 24 Months 2 Days 29 If less than one day hr. min.

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

10. Usual occupation U.S. Coast Guard

11. Industry or business

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

MOTHER
14. Maiden name Lillie Wear
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Raymond Roberts
(b) Address 5914 Bermuda Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation Walhalla Cemetery

18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand Blvd.

19. (a) JUN 4 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd. year 1945 hour 8.40 minute P. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Internal hemorrhage following gunshot wound of liver Self Gt Inflicted in the basement of Home 5914 Bermuda Drive Ferguson Missouri around 6.20 a.m.

Due to June 2 1945

Duration

Other conditions
(Include pregnancy within 3 months of death)

164 C

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) Suicide

(b) Date of occurrence June 2 1945

(c) Where did injury occur? St Louis Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)

While at work? (e) Means of injury Gr above

23. Signature Alfred Perry (M. D. or other)

Address Deputy Coroner Date signed 6/4/45

(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.....Earl C. Brown

Licensed Embalmer No.....1578

P. O. Address.3710 N. Grand B

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.