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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 10 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15135

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3862

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)
In this community

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. 2649 Allen
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LOUIS B. ROBERTS

3. (b) If veteran, name war --

3. (c) Social Security No. 496-30-7534

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Frances

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

7. Birth date of deceased January (Month) 20 (Day) 1882 (Year)

8. AGE: Years 64 Months 3 Days 6 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Retired Letter Carrier

11. Industry or business

FATHER
12. Name Herbert Robert
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

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

16. (a) Informant Helen Herman
(b) Address 3451 Sidney

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/29/46 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Wacker-Weldele
(b) Address 3634 Gravois Ave.

19. (a) APR 29 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 year 1946 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from April 22, 1946, to April 26, 1946, that I last saw him alive on April 26, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Hemmorhage from gastro intestinal tract, unknown site

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Not done

Duration

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)
While at work? (Specify yes or no) (Place of injury)

23. Signature R. L. Stubblefield (M. D. or other)
Address 1420 Grattan Date signed 4-27-46

(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 Frank J. Hyland

Licensed Embalmer No. 2645

P. O. Address Ft Lorraine

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.