

Registration District No. **299** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County St. Louis, Missouri.
 (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 1 1/2 days
Specify whether
 In this community 2.5 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis 2317
(If outside city or town limits, write "RURAL")
 (d) Street No. 1560 Lafayette Ave
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM ROBERTS
 3. (b) If veteran, name war WW 3. (c) Social Security No. 2
 4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Allie 6. (c) Age of husband or wife if alive 55 years
 7. Birth date of deceased September 30 1875
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 25th
 year 1946 hour 8:10 minute A M.
 21. I hereby certify that I attended the deceased from Sept. 25th
1946 19 to Sept. 25th 19 46
 that I last saw him im alive on Sept. 25th 19 46
 and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 11 Days 25
 If less than one day hr. min.

Immediate cause of death Strangulated transverse colon inguinal hernia
 Due to _____
 Due to _____
 Other conditions 172
(Include pregnancy within 3 months of death)

9. Birthplace Cincinnati, Ohio
(City, town, or county) (State or foreign country)
 10. Usual occupation Janitor
 11. Industry or business Retired
MOTHER FATHER
 12. Name William 9
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name Wickerson 4
 15. Birthplace _____
(City, town, or county) (State or foreign country)

Major findings: Of operations not done
 Of autopsy above
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Allie Roberts
 (b) Address 1560 Lafayette Ave
 17. (a) Burial (b) Date thereof 9-27-46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Matthews Cem
 18. (a) Signature of funeral director H. W. McLaughlin
 (b) Address 5301 Lafayette Ave
 19. (a) SEP 27 1946 (b) J. F. Budrick
(Date received from registrars) (Registrar's signature)

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 0
 23. Signature W. Lafayette 9/25/46 M. D. or other _____
 Address _____ Date signed _____

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..... *W. Naaper*

Licensed Embalmer No. *3830*

P. O. Address *2301 Fayette 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.

318 STANDARD CERTIFICATE OF DEATH 1003

State File No. _____

Registrar's No. 8307

Registration District No. _____

Primary Registration District No. _____

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:
(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

3. (a) PRINT FULL NAME William Roberde
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased 9-30-1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 11 25 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-27-46 (b) J. F. Bredebeck
(Date received local registrar) (Registrar's signature) 1946

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH, Month 9 day 25
year 1946 hour _____ minute _____ 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 _____ Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MEDICAL CERTIFICATION

PHYSICIAN

Underline the cause to which death should be charged statistically.

661 11 1946

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