

V. S. No. 2
00M-5-43
Rev. 5-17-39

8016

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 24 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 360

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days 0
Lifetime (Specify whether years, months or days)

3. (a) PRINT FULL NAME JERRY LEE ROBERTS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color of race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased October 26, 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

0 4 14 hr. min.

9. Birthplace St. Joseph, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business None

12. Name Edward Roberts

13. Birthplace St. Joseph, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Ella Louise Scott

15. Birthplace St. Joseph, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Roberts (father)

(b) Address 2125 So. 4th St., City

17. (a) Burial (b) Date thereof 3/12/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director John E. [Signature]
(Specify type of place) (e) Means of injury

(b) Address 6054 Pryor Ave. City

19. (a) 3-14-47 (b) E. G. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2125 So. 4th St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10,
year 1947 hour 8: minute 00 P.M.

21. I hereby certify that I attended the deceased from 3-6-47
_____, 19_____, to Mar 10, 1947, 19_____;
that I last saw him alive on Mar. 10, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Dehydration
autogastroenteritis
mal-nutrition

Due to _____

Due to _____

Other conditions 1197
(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? _____

23. Signature [Signature] (M. D. or other)

Address 620 Francis Date signed 3-12-47

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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, ~~only~~.....

Roland D. Clark

Registered Apprentice No.

working under my personal supervision.

Signed:

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, Mo.*

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.