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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 21 1947

Registration District No. 918

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25985

Primary Registration District No. 1003

Registrar's No. 6693

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

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:
St Lukes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St Clair 999

(c) City or town Edgemont Station 11
(If outside city or town limits, write "RURAL")

(d) Street No. N.R. 0
(If rural, give location) 2

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

If yes, name country

3. (a) PRINT FULL NAME Thomas Knox Roberts

3. (b) If veteran, name war nil

3. (c) Social Security No. 702-09-6338

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Willie

6. (c) Age of ~~husband~~ or wife if alive 66 years

7. Birth date of deceased March 27 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	3	18	hr. min.

9. Birthplace Willow Springs Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired R,R, Employ

11. Industry or business

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

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

16. (a) Informant Willie Roberts (Willie Roberts)

(b) Address Edgemont Station, Illinois

~~Burial~~ (a) ~~Burial~~ Removal (b) Date thereof 7/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ MT Carmel) Belleville, Ill

18. (a) Signature of funeral director Nell, Walsh, Barnes

(b) Address 1416 St Louis, East St Louis Ill

19. (a) [illegible] (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15th
year 1947 hour 1 minute 30 p M.

21. I hereby certify that I attended the deceased from 7-8/47
, 19 , to 7/15 , 1947
that I last saw him alive on 7/15 , 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	5 hrs.
Due to Art Sclerosis Hypertension	
Due to Hypertrophied prostate	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations

Of autopsy above

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

22. If death was due to external causes, fill in the following:

(c) 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 0

23. Signature G. L. Krause (M. D. or other)

Address 3720 Washington Date signed 7/16/47

(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.....

Licensed Embalmer No. 3881

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.