

S. No. 2  
1-1/47  
5-17-39

FILED OCT 4 1947 **318**

Registration District No. ....

Primary Registration District No. **1003**

Registrar's No. **8971**

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:  
**Honer G. Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **15 days**  
(Specify whether

In this community.....  
years, months or days)

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. **3137 Bell**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME **Mable Waltzie Roberts**

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex **Female** 5. Color or race **col**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **May 10th 1879**  
(Month) (Day) (Year)

8. AGE: Years **68** Months **4** Days **10**  
If less than one day hr. min.

9. Birthplace **Springfield Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business.....  
12. Name **John Jones**  
13. Birthplace **New Orleans La**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Sophia Coker**  
15. Birthplace **Yellville Ark**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Patient Statement**  
(b) Address **3137 Bell Ave**

17. (a) **burial** (b) Date thereof **9-26-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. H. Handle & Son**  
(b) Address **3133 Bell Ave**

19. (a) **SEP 26 1947** (b) **J. J. Breda**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **20**  
year **1947** hour **9** minute **25 P. M.**

21. I hereby certify that I attended the deceased from **Sept. 5**, 19**47** to **Sept. 20**, 19**47**  
that I last saw her alive on **Sept. 20**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Cervix with Metastasis**  
Duration **Undet.**

Due to.....

Due to.....

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy **No**

PHYSICIAN

Underline the cause of 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?..... (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.....

Signature **John B. Clayer** (M. D. or other)  
Address **2601 N Whittier** Date signed **9/22/47**

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

MOTHER FATHER

*Handwritten initials*

**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 *S. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 Chouteau*

**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.