.S. No. 300
EV. 10.48

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FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3176

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. #16

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

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY [illegible]

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
c. LENGTH OF STAY (in this place) 33yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Monumental Dead HOMER G. PHILLIPS HOSPITAL

d. STREET ADDRESS (If rural, give location) 3221 Lasalle St.

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) W c. (Last) Roberts

4. DATE OF DEATH (Month) Jan. (Day) I (Year) 1949

5. SEX Male 2
6. COLOR OR RACE Col
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH Aug.26.1884
9. AGE (In years last birthday) 64 IF UNDER 1 YEAR Months 4 Days 6 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ala.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Not Known
13b. MOTHER'S MAIDEN NAME Not Known
14. NAME OF HUSBAND OR WIFE Dead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 489-12-7198
17. INFORMANT'S SIGNATURE OR NAME Edward W Roberts.Jr. ADDRESS 11205O Compton

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Generalized Peritonitis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Perforation of Diverticulum of Duodenum
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

572 123

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Coroner
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 1/4/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Buril
24b. DATE 1-6- 1949
24c. NAME OF CEMETERY OR CREMATORY Oakdale
24d. LOCATION (City, town, or county) (State) St. Louis County, MO

DATE REC'D BY LOCAL REG. JAN 3 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE S. J. Watson ADDRESS 2269 Chouteau

(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

..... Student Embalmer No. .....

working under my personal supervision.

Signed S. J. Watson

Signed.....
Student Embalmer

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.