

STANDARD CERTIFICATE OF DEATH

82711

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6980

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY <i>000</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. <i>J</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis <i>17</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 2515 Chester <i>10</i>	
3. NAME OF DECEASED (Type or Print) a. (First) RAY A. b. (Middle) ROBERTSON c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) August 9th, 1949
5. SEX <i>M</i> male	6. COLOR OR RACE <i>A</i> White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH April 29, 1904
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner	11. BIRTHPLACE (State or foreign country) Missouri <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Vera Robertson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Vera Robertson, 2515 Chester ADDRESS
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from Esophageal Varices ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cirrhosis of liver DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <i>12th</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>5810</i>	
22. I hereby certify that I attended the deceased from <u>8/9/49</u> to <u>8/9/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8/9/49</u> , and that death occurred at <u>3:11 pm</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>John W. ...</i>		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 8/9/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-12-49	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. AUG 10 1949		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

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

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.

Student
Student Embalmer

Signed

Licensed Embalmer No.

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.