

FILED NOV 10 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35519
9389

318

1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Venice	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If rural, give location) W.R. 422 Weaver Street	

3. NAME OF DECEASED (Type or Print) a. (First) HEZEKIAH	b. (Middle)	c. (Last) ROBERTSON	4. DATE OF DEATH (Month) (Day) (Year) Oct 28 1949
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5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH March 25, 1900	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed laborer	10b. KIND OF BUSINESS OR INDUSTRY U. S. Depot	11. BIRTHPLACE (State or foreign country) Newton, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George Robertson	13b. MOTHER'S MAIDEN NAME Sophie Bailey	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS annie Smith 422 Weaver Street Venice, Illinois
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATIONS		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) starting the underlying cause last. DUE TO (b) Nephritis - (hemiplegia last) 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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) STATE
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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? 592X
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22. I hereby certify that I attended the deceased from 7/25, 1949, to 10/28, 1949, that I last saw the deceased alive on 10/28, 1949, and that death occurred at 10 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. A. Warden M.D.	23b. ADDRESS 930 N 2nd St	23c. DATE SIGNED 10/31/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Remove	24b. DATE Oct. 31, 1949	24c. NAME OF CEMETERY OR CREMATORY East St. Louis	24d. LOCATION (City, town, or county) (State) Ill.
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DATE RECEIVED BY LOCAL HEALTH DEPARTMENT OCT 31 1949	REGISTRAR'S SIGNATURE J. B. L... Marshall	25. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS E. St. Louis, Ill.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 48

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 Thomas M. Huber

Licensed Embalmer No. 4479

P. O. Address St Louis, 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.