

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39540

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3063</u>		Registrar's No. <u>4366</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis County</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. LENGTH OF STAY (in this place) <u>5 YEARS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton, Mo.</u>		96 2 3 D		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>59 Lake Forest</u>				d. STREET ADDRESS (If rural, give location) <u>59 Lake Forest</u>				
3. NAME OF DECEASED a. (First) <u>Gertrude M.</u> b. (Middle) _____ c. (Last) <u>Robertson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9th, 1949</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 23rd, 1876</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Murphysboro, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Chas. LaBarre</u>		13b. MOTHER'S MAIDEN NAME <u>Corinne Luciere</u>		14. NAME OF HUSBAND OR WIFE <u>Elmer J. Robertson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. LeRoy L. Robertson</u> ADDRESS <u>59 Lake Forest</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Valvular disease of the heart (Mitral stenosis)</u>				DUE TO (b) _____				<u>6 yrs.</u>
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>				DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>Osteo-arthritis</u>								<u>410X</u> <u>8 yrs.</u>
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>NOV. 8, 1949</u> , to <u>NOV. 9, 1949</u> , that I last saw the deceased alive on <u>Nov. 8, 1949</u> , and that death occurred at <u>7:50 a. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Erroy Newman M.D.</u> (Degree or title)				23b. ADDRESS <u>3539 Hartford St.</u>		23c. DATE SIGNED <u>Nov. 10, 1949</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/12.49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>11-10-49</u>		REGISTRAR'S SIGNATURE <u>Herbert B. Wombe M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kraeger-Voss, Inc.</u> ADDRESS <u>3402 N. Kingshighway</u>				

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ray W. Wilkinson

Licensed Embalmer No. 3575

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.