

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44220**
0401

FILED JAN 28 1952

BIRTH NO. _____ REG. DIST. NO. **318** 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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY 2064
c. LENGTH OF STAY (In this place) 9 hrs 45 min		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			
e. STREET ADDRESS (If rural, give location) 4803a Page			

3. NAME OF DECEASED a. (First) Leroy			b. (Middle)			c. (Last) Roberts			4. DATE OF DEATH (Month) (Day) (Year) 12 31 51			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH 12-31-51			9. AGE (In years last birthday) 9		IF UNDER 1 YEAR 0	IF UNDER 12 HRS. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Leroy Roberts			13b. MOTHER'S MAIDEN NAME Ann Morgan			14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME Kathleen M. Sherard, R.N.			ADDRESS 2601 N. Whittier		

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 **12-31-**, 19**51**, to **12-31-**, 19**51**, that I last saw the deceased alive on **12-31-**, 19**51**, and that death occurred at **8:52p m.**, from the causes and on the date stated above. **776**

23a. SIGNATURE [Signature] (Degree or title) M. D.			23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 1-9-52		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)		

DATE RECD BY LOCAL HEALTH DEPT.		REGISTRAR'S SIGNATURE [Signature]			25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service			ADDRESS		
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed
Student Embalmer

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.