

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 9 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5820**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 weeks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Decatur		8120
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes, Hospital			d. STREET ADDRESS (If rural, give location) ✓		
3. NAME OF DECEASED (Type or Print)		a. (First) LAURA	b. (Middle) L.	c. (Last) ROBY	4. DATE OF DEATH (Month) (Day) (Year) 6-18-52
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10-19-1893	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Mins.	11. BIRTHPLACE (City and State or Foreign Country) West Salem, Ill.		12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home			
13a. FATHER'S NAME Gustav Kortge		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE James E. Roby	
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. none	17. INFORMANT'S SIGNATURE OR NAME Verne Roby, Decatur, Ill.		
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				INTERVAL BETWEEN ONSET AND DEATH 4 weeks.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Hemorrhage, Subarachnoid, Spontaneous.				
ANTECEDENT CAUSES	DUE TO (b) Aneurysm, Sacculon, anterior cerebral artery, rupt.				
DUE TO (c)	Coronary occlusion, old.				
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 checked="" type="checkbox"/> NO <input 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? 330X			
22. I hereby certify that I attended the deceased from 5-25 , 19 52 , to 6-18 , 19 52 , that I last saw the deceased alive on 6-19 , 19 52 , and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE George E. Rouche		(Degree or title) MD	23b. ADDRESS 3720 Washington Ave, St. Louis		23c. DATE SIGNED 6-19-52
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 6-19-52	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Decatur, Ill.		
DATE REC'D BY LOCAL REG. JUN 23 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Brintlinger, Decatur, Ill.		

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

STATEMENT BY LICENSED EMBALMER

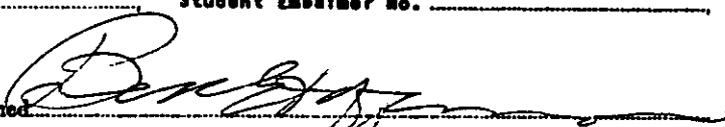
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4366

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.