

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

State File No. 12228

No. 300  
10-48

FILED MAR 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2539

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2119</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4134 St. Louis</u>	

3. NAME OF DECEASED (Type or Print) <u>Carrie Roberts</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 4 1953</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>	
8. DATE OF BIRTH <u>April 13 1885</u>		9. AGE (In years last birthday) <u>67</u>		10. IF UNDER 1 YEAR <u>10</u> MONTHS <u>21</u> DAYS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Columbia, Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>George Frierson</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie ?</u>	
13c. NAME OF HUSBAND OR WIFE <u>James Roberts</u>		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>John N. Gordon</u>		17. ADDRESS <u>717 N. Compton</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Disease</u>		Cerebral Vascular Disease				<u>Undet.</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				DUE TO (b) <u>Undetermined</u>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Psychosis with Organic Brain Disease</u>					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>None</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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR		<u>3082</u>	

22. I hereby certify that I attended the deceased from 8-13, 1952, to 3-4, 1953, that I last saw the deceased alive on 3-4, 1953, and that death occurred at 1:30p m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>		23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>3-5-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Mar. 7, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Randle &amp; Son</u>		25. ADDRESS <u>3133 Bell Ave.</u>	

DATE REC'D BY LOCAL REG. <u>MAR 7 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Randle &amp; Son</u>		25. ADDRESS <u>3133 Bell Ave.</u>	
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed J. J. Watson

Licensed Embalmer No. 269

P. O. Address 279 Mendocino

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.