

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26819**  
Registrar's No. **6724**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|                                                                                               |  |                                                                                                                                       |                                                                                                                        |
|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY _____                                                          |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Illinois</b><br>b. COUNTY _____ |                                                                                                                        |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> |  | c. CITY OR TOWN <b>Tamaroa</b>                                                                                                        | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>2 days</b>                                               |  | e. STREET ADDRESS (If rural, give location) <b>Route #2</b>                                                                           |                                                                                                                        |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>                         |  |                                                                                                                                       |                                                                                                                        |

|                                                            |            |             |           |                                |         |       |        |
|------------------------------------------------------------|------------|-------------|-----------|--------------------------------|---------|-------|--------|
| 3. NAME OF DECEASED (Type or Print) <b>WILLIAM ROBERTS</b> | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH <b>7-4-53</b> | (Month) | (Day) | (Year) |
|------------------------------------------------------------|------------|-------------|-----------|--------------------------------|---------|-------|--------|

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|--------------------|-------------------------------|-----------------------------------------------------------------------|-----------------------------------|-------------------------------------------|------------------------|-----------------------|----------------------|
| 5. SEX <b>male</b> | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>11-6-1871</b> | 9. AGE (In years last birthday) <b>82</b> | IF UNDER 1 YEAR Months | IF UNDER 1 HRS. Hours | IF UNDER 1 MIN. Min. |
|--------------------|-------------------------------|-----------------------------------------------------------------------|-----------------------------------|-------------------------------------------|------------------------|-----------------------|----------------------|

|                                                                                                                  |                                                |                                                                          |                                         |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired miner</b> | 10b. KIND OF BUSINESS OR INDUSTRY <b>miner</b> | 11. BIRTHPLACE (City and State or Foreign Country) <b>Troy, Illinois</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |
|------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------|

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|------------------------------------------|------------------------------------------------|----------------------------------------------------|
| 13a. FATHER'S NAME <b>Robert Roberts</b> | 13b. MOTHER'S MAIDEN NAME <b>Mattie Lefler</b> | 14. NAME OF HUSBAND OR WIFE <b>Doretha Roberts</b> |
|------------------------------------------|------------------------------------------------|----------------------------------------------------|

|                                                                             |                                     |                                                            |               |
|-----------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> | 16. SOCIAL SECURITY NO. <b>none</b> | 17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records,</b> | ADDRESS _____ |
|-----------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------|---------------|

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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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                                                                                                                                                                                            |  | INTERVAL BETWEEN ONSET AND DEATH       |
|                                                                                                                                                                                                                                | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of urinary bladder</b>                                                                                                                       |  | <b>18-20 months</b>                    |
|                                                                                                                                                                                                                                | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Hypertrophy of prostate</b><br>DUE TO (c) <b>and Carcinoma of bladder</b> |  | <b>years</b><br><b>Probably months</b> |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocarditis and diabetes.</b>                                                           |                                                                                                                                                                                                                  |  |                                        |

|                                      |                                                               |                                                                       |
|--------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------|
| 19a. DATE OF OPERATION <b>7-4-53</b> | 19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of bladder.</b> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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|------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, swimming, etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>181X</b> |
|------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|

|                                                          |                                                                                                        |                                        |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>181X</b> |
|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------|

22. I hereby certify that I attended the deceased from **11 A.M. 7-4-** 19**53**, to **6 P.M. 7-4-** 19**53**, that I last saw the deceased alive on **7-4-** 19**53**, and that death occurred at **8:20 P. m.**, from the causes and on the date stated above.

|                                                            |                                                           |                                |
|------------------------------------------------------------|-----------------------------------------------------------|--------------------------------|
| 23a. SIGNATURE <b>Andy Hall, Jr. (ANDY HALL, JR.) M.D.</b> | 23b. ADDRESS <b>University Club Bldg., St. Louis, Mo.</b> | 23c. DATE SIGNED <b>7-7-53</b> |
|------------------------------------------------------------|-----------------------------------------------------------|--------------------------------|

|                                                |                         |                                    |                                                                    |
|------------------------------------------------|-------------------------|------------------------------------|--------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL <b>Removal</b> | 24b. DATE <b>7-6-53</b> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) <b>DuQuoin, Ill.</b> |
|------------------------------------------------|-------------------------|------------------------------------|--------------------------------------------------------------------|

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|--------------------------------------------|-----------------------------------------------|---------------------------------------------------------|------------------------------|
| DATE REC'D BY LOCAL REG. <b>JUL 7 1953</b> | REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Schroeder F.H.,</b> | ADDRESS <b>DuQuoin, Ill.</b> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No..... 43

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.