

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25150**  
Registrar's No. **6102**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>6102</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (In this place) <b>2 wks</b>		c. CITY OR TOWN <b>Murphysboro</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>1302 Maple Street., 8120 8</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Emily</b> b. (Middle) <b>Katherine</b> c. (Last) <b>Roberts</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 5, 1954</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>		8. DATE OF BIRTH <b>April 18, 1885</b>		
9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Teacher</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Murphysboro, Illinois</b>		
11. BIRTHPLACE (City and State or Foreign Country) <b>Murphysboro, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Paul Roberts</b>				
13b. MOTHER'S MAIDEN NAME <b>Rosa Ryall</b>		14. NAME OF HUSBAND OR WIFE <b>Nil</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No Nil</b>				
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>R.R. Barringer, Murphysboro, Ill.</b>				ADDRESS _____		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Primary carcinoma of Liver</b> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>155X</b>				22. I hereby certify that I attended the deceased from <b>6-21-1954</b> , to <b>7-5-1954</b> , that I last saw the deceased alive on <b>7-4-1954</b> , and that death occurred at <b>5:30A</b> m., from the causes and on the date stated above:		
23a. SIGNATURE <b>Carl J. Ker M.D. 918 S. Humphreys</b>		23b. ADDRESS _____		23c. DATE SIGNED <b>7-6-54</b>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>7-6-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Murphysboro, Illinois</b>		
DATE REC'D BY LOCAL REG. <b>JUL 6 1954</b>		REGISTRAR'S SIGNATURE <b>Carl J. Ker M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd</b>				

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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *37*

P. O. Address *St. Louis*

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.