

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31410

State File No. 7866
Registrar's No. 7866

FILED SEP 29 1955

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		Registrar's No. _____					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION. Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 21 2706 Stoddard Street									
3. NAME OF DECEASED (Type or Print) a. (First) Frances			b. (Middle) _____			c. (Last) Roberson			4. DATE OF DEATH (Month) (Day) (Year) 9 3 55				
5. SEX F		6. COLOR OR RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH April 15 1900		9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months 5 Days 2		IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____				10b. KIND OF BUSINESS OR INDUSTRY Nil		11. BIRTHPLACE (City and State or Foreign Country) Humbolt Tenn				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME George Smith				13b. MOTHER'S MAIDEN NAME Sallie Hillard				14. NAME OF HUSBAND OR WIFE Allen Roberson					
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 ADDRESS Jessie Booth 2706 Stoddard							
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Undetermined. 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. Hypertensive Cardio-vascular disease. Old Left Cerebral Vascular Accident								INTERVAL BETWEEN ONSET AND DEATH Undt.			
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) 443 X							
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? _____									
22. I hereby certify that I attended the deceased from 8-18- 1955 , to 9-3- 1955 , that I last saw the deceased alive on 9-3- 1955 , and that death occurred at 9:55a : m., from the causes and on the date stated above.													
23a. SIGNATURE Frank P. Richards (Degree or title) M.D.				23b. ADDRESS 2601 N. Whittier Street				23c. DATE SIGNED 9-3-55					
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-8-55		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cem. Wellston				24d. LOCATION (City, town, or county) (State) MO.					
DATE REC'D BY LOCAL REG. SEP 7 1955		REGISTRAR'S SIGNATURE Carl Smith				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Walton 270 Stoddard							

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

H. Claude Gordon

Licensed Embalmer No.

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P. O. Address

45756

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/she shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.