

FILED APR 26 1957

STANDARD CERTIFICATE OF DEATH

15200
STATE FILE NUMBER
3400

Registration District No. 318 Primary Registration District No. 1003 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, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's			Length of stay in lb 50 Years		d. STREET ADDRESS 1028 Dolman		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE ROBERTS				First Middle Last		4. DATE OF DEATH Month Day Year April 7, 1957		
5. SEX Male <input type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-1902		
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Metro Sewer Div.		11. BIRTHPLACE (City and state or country) Centralia, Illinois		
12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Ezra Roberts				14. MOTHER'S MAIDEN NAME Lillian Truesdale				
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. 490 12 7129		17. INFORMANT Myrtle Roberts, 1028 Dolman		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION							INTERVAL BETWEEN ONSET AND DEATH 2wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							420.1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hemorrhagic Gastritis, Hypoprothrombinemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from 3-28-57 to 4-7-57 and last saw her alive on 4-7-57 Death occurred at 9:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Charles Stahl MD (Degree or title)				22b. ADDRESS 7430 Virginia, St. Louis, Mo.		22c. DATE SIGNED 4-9-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-10-1957	23c. NAME OF CEMETERY OR CREMATORY Hiram Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette				ADDRESS		25. DATE RECD. BY LOCAL REG. APR 9 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

Health,
& Welfare
Public
Service300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

esb

STATEMENT

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 *L. P. Cooper*

Licensed Embalmer No. *363*

P. O. Address *2317 Ray*

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.