

15202

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED APR 26 1957

STATE FILE NUMBER 3517

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

 Health,
 & Welfare
 S. Public
 Health Service

 S. 300
 v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Osage | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St. Louis Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Bland Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital Length of stay in lb 25 hrs | | d. STREET ADDRESS (If outside, give location) R. F. D. # 3 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jesse Middle Theodore Last Roberts | | 4. DATE OF DEATH Month April Day 10 Year 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 Dec. 26- 1892 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Hand R.R. | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 64 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) Maries County, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Roberts | | 14. MOTHER'S MAIDEN NAME Jane Drysee | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. Nil. | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Mrs. Eva Roberts, Bland, Mo. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction | | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) Coronary arteriosclerosis |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | DUE TO (c) |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 420.0 |
| 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 WORK <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 April 9, 1957 to death and last saw him alive on April 10, 1957 Death occurred at 9:05 am on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Robert C. Koenig MD | | 22b. ADDRESS 14 Forsyth Walk, Clayton 5, Mo. | 22c. DATE SIGNED 4-11-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4-10-57 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) (State) Maries County, Mo. |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. | ADDRESS | 25. DATE RECD. BY LOCAL REG. APR 12 '57 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P. |

(Licensed Embalmer's Statement on Reverse Side)

Grade

Michael

St. Louis

x

St. Louis

MAY 1 1957

Desonnes Hospital

APR 10 1957

Roberta

Roberta

1957

Dec. 26-1905

White

Male

U.S.A.

Marion County, Mo.

Section 101-1-1

Jane Dwyer

William Roberts

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 *E. E. Remelius*

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.

1-10-57

Remove

Albert H. Hoppe, 1000 Washington Blvd.