

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012220
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **2524**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) 7	d. CITY OR TOWN St. Louis,
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital.		STREET ADDRESS (If rural, give location) 3038 Magazine	
3. NAME OF DECEASED a. (First) Asa b. (Middle) c. (Last) Roberts.		4. DATE OF DEATH (Month) (Day) (Year) February 27- 1958.	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.	8. DATE OF BIRTH Dec. 6, 1890
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (City and State or Foreign Country) Perry Co, Alabama.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Calvin Roberts		13b. MOTHER'S MAIDEN NAME Millie Neal	
14. NAME OF HUSBAND OR WIFE Mrs. Ella Roberts		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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Norma Jones 3516a Cozens Ave.	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Metastatic Carcinoma Type INTERVAL BETWEEN ONSET AND DEATH 7 yrs. ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) Breastatic Carcinoma II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 177+	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 July 10, 1957 , to February 27, 1958 that I last saw the deceased alive on Feb. 27, 1958 , and that death occurred at 5:45 AM from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.		23b. ADDRESS 5800 Arsenal	
23c. DATE SIGNED 2/27/58		24. NAME OF CEMETERY OR CREMATORY Father Dickson	
24. BURIAL, CREMATION, REMOVAL (Specify) Removal		24. LOCATION (City, town, or county) (State) Saint Louis Co., Mo.	
24b. DATE 3-6-58		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Metropolitan Funeral Sys., Inc. 5010 Enright Ave.	
DATE REC'D BY LOCAL REG. MAR 3 '58		REGISTRAR'S SIGNATURE Carl Smith	

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 *John K. Cunningham*.....
Licensed Embalmer No. 4476.....

P. O. Address 2405 Marcus A.....

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.