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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003436
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 533

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis,Mo — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Eproute to Peoples Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2119 1724 a.N.Whittier — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Addison — Middle: — Last: Roberts
4. DATE OF DEATH: Month 1 Day 14 Year 1959
5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH: May 5,1909
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY: Coronado Hotel
11. BIRTHPLACE (City and state or country): Indianapolis,Indiana /
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Addison Roberts,Sr
13b. MOTHER'S MAIDEN NAME: Estelle Poston
14. NAME OF HUSBAND OR WIFE: Bernadine Roberts
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 493-36-1100
17. INFORMANT: Dollean Alexander — Address: 4837 Hammett Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gastro-Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Duodenal Ulcer — Unknown
DUE TO (c) 541.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Feb. 1957, to Jan 14,1959 and last saw him alive on 1-9-59
Death occurred at 10:05 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R.L. Smith, M.D. (Degree or title)
22b. ADDRESS: 1N.Jefferson St louis
22c. DATE SIGNED: 1-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1-19-59
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis County,Missouri

24. FUNERAL DIRECTOR — ADDRESS: C.W.Roberts Und.Co 1416 N.Taylor Ave
25. DATE RECD. BY LOCAL REG.: JAN 16 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 James A. Carter

Licensed Embalmer No. 4681

P. O. Address .....

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.