

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023333

STATE FILE NUMBER  
2 6018

FILED JUL 7 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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S. 300  
1-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Granite City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Length of stay in 1b <b>3 weeks</b>	d. STREET ADDRESS <b>3728 North Avenue</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>L.</b> Last <b>Roberts</b>			4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1902</b>		9. AGE (In years last birthday) <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Filling Station</b>	11. BIRTHPLACE (City and state or country) <b>Alexandria, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank Roberts</b>		13b. MOTHER'S MAIDEN NAME <b>Minnie Waldon</b>		14. NAME OF HUSBAND OR WIFE <b>Ruth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>360-24-7281</b>		17. INFORMANT <b>Mrs. Edw. Roberts</b> Address <b>Granite City, Illinois</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma to brain</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 wks.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of lungs.</b>					<b>6 months</b>
DUE TO (c) <b>163x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Emphysema</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ 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 <b>11-25-52</b> to <b>6-24-59</b> and last saw <sup>him</sup> alive on <b>6-24-59</b> Death occurred at <b>9:15 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>M. Norman Orpel</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>100 North Euclid</b>		22c. DATE SIGNED <b>6/25/59</b>
23a. BURIAL CREMATION, REMOVE (Specify) <b>Removal to Madison, Ill.</b>		23b. DATE <b>6/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Edwardsville Illinois</b>
24. GENERAL DIRECTOR <b>Thomas J. Lohrey</b>		ADDRESS <b>Madison, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 25 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ronnie J. Lahey* .....

Licensed Embalmer No. *2792* .....  
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.