MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6426

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. St. Anthony Hosp St. ..... Ward)

File No. .....

Registered No. 1215

2. FULL NAME John Roberts

(a) Residence. No. 3909 Gravois St., 16 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dorothy Roberts

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 9 – 1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	63	3	24	

8. OCCUPATION OF DECEASED 21

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer Street Department

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT William G Roberts
(Address) 3909a Gravois

15. FILED ..... 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 3 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at 9.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries (Subarachnoid Hemorrhage - Fractured Skull) struck by auto in St. Louis, Mo. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Accident (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M.D.

2/4, 1930 (Address) Dep Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Olive

DATE OF BURIAL 2/6 1930

20. UNDERTAKER J. H. Gebken

ADDRESS 2630 Gravois