

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Registration District No.

1003

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town ST. LOUIS 22
(If outside city or town limits, write "RURAL")
(d) Street No. 1232 SOUTH NINTH STR
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JOSEPH ROUBIDOUX

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased OCT. 27 1935
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 8 8 hr. min.

9. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name JOHN ROUBIDOUX

13. Birthplace WIS.
(City, town, or county) (State or foreign country)

14. Maiden name LUCILLE CASH

15. Birthplace ILL.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Roubidoux

(b) Address 1232 So. 9th St

17. (a) BURIAL (b) Date thereof 7-7-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director Hulbert & Kelly

(b) Address 1416 N. Taylor Ave

19. (a) JUL 6 1939 (b) J. G. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5
year 1939 hour 1:35 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Appendicitis

Due to _____

Due to Cont. Peritonitis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____ PHYSICIAN _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of paper) _____
Means of injury _____

28. Signature Joseph M. Green (M.D. or other) _____

Address Deputy Coroner signed 7/6

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Robert McHenry

Licensed Embalmer No. *232*

P. O. Address

St. Louis

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 this body is not embalmed, above space should be left blank.