

DEC 11 1940 791  
Registration District No. **791**

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

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

1. PLACE OF DEATH:

(a) County In route City Hospital  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community about 18 yrs. (Specify whether 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. 1708 Custon Pl  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Roberta Milam

3. (b) If veteran, name was none 3. (c) Social Security No. NONE

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased 7 1877  
(Month) (Day) (Year)

8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mississippi (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Robert Milam

(b) Address 3854 Page Blvd.

17. (a) burial (b) Date thereof 12/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director [Signature]

(b) Address 215 So. Jefferson

19. (a) NOV 30 1940 (b) [Signature]  
(Received local registrar) (Registered Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30  
year 1940 hour 9 minute 30 A.M.

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

Immediate cause of death \_\_\_\_\_

Due to Cerebral apoplexy

Due to [Signature]

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 place) (e) Means of injury 5

23. Signature [Signature] (M. D. or other)

Address [Signature] Date signed 4/30/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 \_\_\_\_\_

*S. J. Watson*

Licensed Embalmer No. *269A*

P. O. Address *2769 Chouteau*

**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.**