

95
No. 2
-1-4-42
-17-39
X26390

Registration District No. **NOV 24 1941**

Primary Registration District No. **1003**

Registrar's No. **8632**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **21 Days**
(Specify whether
In this community..... **Unknown**
years, months or days)

3. (a) PRINT FULL NAME **John Roberts**

3. (b) If veteran, name war..... **Unknown**
3. (c) Social Security No. **Unknown**

4. Sex **Male** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced. **Unknown**
6. (b) Name of husband or wife..... **Unknown**
6. (c) Age of husband or wife if alive **Unknown** years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years **84** Months Days If less than one day
hr. min.

9. Birthplace **Unknown** / (City, town, or county) (State or foreign country)

10. Usual occupation **Unknown**

11. Industry or business **Unknown**

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 **Ann Morrison**
(b) Address **St. Louis City Hospital #1**

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **NOV 20 1941** (b) **J. J. Brudick** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **099**
(c) City or town **St. Louis** / **127**
(If outside city or town limits, write "RURAL")
(d) Street No. **1516 North Grand Ave.**
(If rural, give location)
(e) Citizen of foreign country? **Unknown** / (Yes or No)
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **17**,
year **1941** hour **1:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **September 27**, 19**41**, to **October 17**, 19**41**,
that I last saw him alive on **October 17**, 19**41**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **None**

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 place) (e) Means of injury

23. Signature **R. J. Milligan** (M. D. or other) **10/17/41**
Address **1515 Lafayette Avenue** Date signed

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

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.....

Licensed Embalmer No.....

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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33674**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County _____
 - (b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
 - (c) Name of hospital or institution: _____
(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 _____ (b) County _____
- (c) City or town _____
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John Roberts**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **unk**

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

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

8. AGE:	Years	Months	Days	If less than one day
	84			11 min.

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **DEC 5 1941** (b) **J. F. Bruckner** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** Day _____ Year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ live on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: 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 place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

