

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32371

FILED OCT 28 1942 318

State File No. 8730
Registrar's No.

Registration District No. Primary Registration District No. 100

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Bros. Hospt. ()
(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

3. (a) PRINT FULL NAME James Wm. Roberts

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

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 decedent Nov. 10th 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 11 9 hr. min.

9. Birthplace Randolph County, Mo. ()
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name William C. Roberts
13. Birthplace Unknown Kentucky ()
(City, town, or county) (State or foreign country)
14. Maiden name Adaline Roberts
15. Birthplace Monroe County, Mo. ()
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Vick Roberts
(b) Address Cairo, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-42
(Month) (Day) (Year)
(c) Place: burial or cremation Moberly, Mo.

18. (a) Signature of funeral director Snow Funeral Home
(b) Address: Moberly, Mo.
19. (a) J. F. Smith (Date received local registrar) (b) J. F. Smith (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19th 42
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 7/42 to Oct. 19/42, 19____; that I last saw him alive on Oct. 19/42, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor with cerebral edema
Spongiosarcoma multiforme

Due to Malignant

Due to 54 1/2

Other conditions Elevated conglutinin
(Include pregnancy within 3 months of death) infected

Major findings: Of operations _____

Of autopsy Spongiosarcoma multiforme with cerebral edema

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 E. F. Sessin (M. D. or other) _____
Address 3247 rick Blvd Date signed 10/19

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

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

Rev. 6-17-39

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.....

W. Wilkinson
.....
Licensed Embalmer No..... *3575*

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, above space should be left blank.