

FILED AUG 12 1943  
Registration District No. 318

Primary Registration District No. 1003

Registrar's 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:  
**4989a Tholozan Ave. /**  
(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**  
(If outside city or town limits, write "RURAL")  
 (d) Street No..... **4989a Tholozan Ave.**  
(If rural, give location)  
 (e) Citizen of foreign country?.....  
(Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME **Edith Isophene Roberts**

3. (b) If veteran, name war..... **None**

3. (c) Social Security No..... **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30th**  
 year **1943** hour **11:50** minute **P.M.** M.

21. I hereby certify that I attended the deceased from **May 28, 1942**  
 1942 to **July 13, 1943**  
 that I last saw her alive on **July 14, 1943**  
 and that death occurred on the date and hour stated above.

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Married**

6. (b) Name of husband or wife..... **Cecil K. Roberts**

6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **Aug. 16th 1892**  
(Month) (Day) (Year)

Immediate cause of death **Carcinoma of Ovaries, Rt. & Left**

Due to.....

Due to.....

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

**50** **11** **14** hr. min.

Other conditions **metastatic carcinoma of abd. viscera**

(Include pregnancy within 3 months of death)

Major findings: **Carcinoma of Ovaries & metastasis to lymph glands**

Of autopsy.....

9. Birthplace **Belle Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Duration **1+ yrs**

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **Barth Hutchison**

13. Birthplace **Belle Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary J. Price**

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

16. (a) Informant **Cecil K. Price**

(b) Address **4989a Tholozan Ave.**

17. (a) **Burial** (b) Date thereof **8-2-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Kriegshauser Mortuaries**

(b) Address **4228 So. Kingshighway Blvd.**

19. (a) **AUG 2 1943** (b) **J. F. Brudeck**  
(Date received local registrar) (Registrar's signature)

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?  
(Specify type of place)

White at work?..... (e) Means of injury.....

23. Signature **Richard Peckolock** (M. D. or other) **MD**  
 Address **4500 Olive St.** Date signed **7/31-43**

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

MOTHER FATHER

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**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 Richard W. Stausand

Licensed Embalmer No. 4007

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.**