S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1947

Registration District No. 818

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 11454

Registrar's No. 3440

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis city
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Louis Children's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State Arkansas (b) County Greene

(c) City or town Paragould
(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 Samuel Isaiah Roberts

3. (b) If veteran, name war None

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 November (Month) 2 (Day) 1945 (Year)

8. AGE: Years 1 Months 4 Days 29 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER

12. Name Paul Roberts

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

14. Maiden name Maxine Robertson

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

16. (a) Informant Paul Roberts

(b) Address Paragould, Arkansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/31/47 (Month) (Day) (Year)

(c) Place: burial or cremation Paragould, Arkansas

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 31 1947 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31 year 47 hour 12 minute 05 A.M.

21. I hereby certify that I attended the deceased from 3-23-, 1947, to 3-31, 1947 that I last saw him alive on 3-31, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia-Bron	
Diarrhea	
Acute Cardiac	
Due to Dilatation.	
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? (Specify type of place)

While at work (e) Means of injury

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

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address Mt Pleasant

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.