

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11455**
Registrar's No. **2325**

FILED MAR 24 1947
318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **o.c.w.**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1506 Tower Grove Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **WALTER A. ROBERTS**

3. (b) If veteran, name war **None** 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Evelyn E.**
6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **June 19 1890**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	8	16	hr. min.

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

10. Usual occupation **Printer**

11. Industry or business **Walters Mfg. Co.**

12. Name **Unknown** 9

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

14. Maiden name **Jane Dorsey** 9

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

16. (a) Informant **Evelyn E. Roberts**

(b) Address **1506 Tower Grove Ave.**

17. (a) **Removal (Rail)** (b) Date thereof **3 8 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. James, Mo.**

18. (a) Signature of funeral director **Kriegshauser Und. Co.**

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

19. (a) **MAR 6 1947** (b) **J. F. Bredegar**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5th**
year **1947** hour **11:50** minute _____ P.M.

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

Immediate cause of death **Cerebral Apoplexy**
Due to **83**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration _____
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 **3**
23. Signature **Patrick E. Taylor** (M.D. or other) **3-6-47**
Address **1300 Clark** Date signed _____

[Handwritten signature]

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. Stovesand*

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.