

FILED APR 23 1947
Registration District No. 317

Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Clayton Richmond Hts
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Marys
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 Days
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
 (c) City or town Belleville
 (If outside city or town limits, write "RURAL")
 (d) Street No. 600 So. High St.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Roberta Grant Fierke
 3. (b) If veteran, name war: ---
 3. (c) Social Security No. -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
 year 1947 hour 10.00 minute ? M.
 21. I hereby certify that I attended the deceased from 22 Mar
1947, to 15 Apr 1947;
 that I last saw her alive on 13 Apr 1947;
 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 Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 9, 1946
 (Month) (Day) (Year)

Immediate cause of death Hepatitis, chronic Duration 5 Mo
 Due to Cause undetermined
 Due to _____
 Other conditions Jaunder, acute
 (Include pregnancy within 3 months of death)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>6</u>	<u>6</u>	hr. _____ min.

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace St. Paul Minn.
 (City, town, or county) (State or foreign country)
 10. Usual occupation None
 11. Industry or business None

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? _____

MOTHER FATHER {
 12. Name Robert Fierke
 13. Birthplace St. Paul Minn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Gineppina DeRubertis
 15. Birthplace Foggia Italy
 (City, town, or county) (State or foreign country)
 16. (a) Informant Robert Grant Fierke
 (b) Address Scott Field, Ill.
 17. (a) Burial (b) Date thereof Apr. 17, 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Walnut Hill
 18. (a) Signature of funeral director _____
 (b) Address 1204 S. 11th St. Belleville, Ill.
 19. (a) 4-17-47 (b) Lois G. Shapley
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
 (e) Means of injury D
 23. Signature Howard L. Lange (M. D. or other)
 Address Belleville, Ill. Date signed 15 Apr 47

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..... *Geo Renner*

Licensed Embalmer No. *2314*

P. O. Address..... *Belleville Ills.*

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.