

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3021**
#1

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Ind. b. COUNTY	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 1-Week	c. CITY OR TOWN Evansville	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 245 Union Blvd.		e. STREET ADDRESS (If rural, give location) R.F.D.# 5	

3. NAME OF DECEASED (Type or Print) Louis Long Roberts			4. DATE OF DEATH Jan. 1, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 26, 1892		9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired attorney		10b. KIND OF BUSINESS OR INDUSTRY Attorney		11. BIRTHPLACE (City and State or Foreign Country) Carlisle, Ind.	
13a. FATHER'S NAME James N. Roberts			13b. MOTHER'S MAIDEN NAME U.K.		14. NAME OF HUSBAND OR WIFE Pauline Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 1 1/2 2		16. SOCIAL SECURITY NO. 1 1/2 2		17. INFORMANT'S SIGNATURE OR NAME Pauline Roberts ADDRESS Carlisle, Ind.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral sclerosis		DUPLICATE OF (a)		Annual	
*This does not mean the mode of dying, such as heart failure, asphemia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		year	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **for several years**, 19____, that I last saw the deceased alive on **Dec 30, 1954**, and that death occurred at **early A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Walter Luten MD (Degree or title)		23b. ADDRESS St Louis Mo		23c. DATE SIGNED Jan 1-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-1-55		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Carlisle, Indiana	
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DATE REC'D BY LOCAL REG. JAN 3 1955		REGISTRAR'S SIGNATURE Charles Smith		25. FUNERAL DIRECTOR'S SIGNATURE Walter Luten ADDRESS 3840 Lindell Blvd.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Francis Williams*.....

Licensed Embalmer No. *3563*.....

P. O. Address *3840 Line*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.