

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6888

State File No.

FILED MAR 21 1955

BIRTH NO. _____ REG. DIST. NO. 312 PRIMARY REG. DIST. NO. 500 Registrar's No. 425

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| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution; residence before institution). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY OR TOWN <u>NORMANDY</u> | | c. CITY OR TOWN <u>OVERLAND PARK</u> | |
| c. LENGTH OF STAY (In this place) <u>107</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORMANDY OSTEOPATHIC</u> | | e. STREET ADDRESS (If rural, give location) <u>9528 TRESSCOTT</u> | |

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| 3. NAME OF DECEASED a. (First) <u>WILLIAM</u> b. (Middle) <u>EDWIN</u> c. (Last) <u>ROBERTS</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>2 - 17 - 55</u> | | |
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| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JUNE 14 1884</u> | 9. AGE (In years last birthday) <u>70</u> | 10. UNDER 1 YEAR Months _____ Days _____ | 11. UNDER 1 HRD. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OWNER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>ST LOUIS MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>WYNN ROBERTS</u> | 13b. MOTHER'S MAIDEN NAME <u>MATHERINE DONN</u> | 14. NAME OF HUSBAND OR WIFE <u>ELIZABETH ROBERTS</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>488-34-4021A</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>EDWIN W ROBERTS</u> ADDRESS <u>9530 TRESSCOTT</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-vascular renal disease?</u> DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) <u>442X</u> |
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| 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? |
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22. I hereby certify that I attended the deceased from _____, 1953, to June, 1954, that I last saw the deceased alive on June, 1954, and that death occurred at 12:11 P.M., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>Matthias Richardson D.D.</u> | 23b. ADDRESS <u>2335 Brown Rd</u> | 23c. DATE SIGNED <u>2-18-55</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE <u>2-19-55</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u> | 24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u> |
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| DATE REC'D BY LOCAL REG. <u>2-18-55</u> | REGISTRAR'S SIGNATURE <u>Dorothy R. Donker MD</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Hilleman</u> ADDRESS <u>Oxford MO</u> |
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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

Signature *Carl F. Hillman*

Licensed Embalmer No. *350*

P. O. Address *Deland*

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.