

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9403 663-037978  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED SEP 26 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>256 days</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp</b>				Inside (limits) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3813 Folsom</b>		(If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Oscar Roberts</b>			4. DATE OF DEATH Month Day Year <b>9 17 63</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>					
8. DATE OF BIRTH <b>3/27/1877</b>		9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			
10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Keysville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>				13a. FATHER'S NAME <b>John Roberts</b>		
13b. MOTHER'S MAIDEN NAME <b>Myra Arthur</b>		14. NAME OF HUSBAND OR WIFE <b>Unavailable</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>No</b>				
17. INFORMANT <b>Kenneth Roberts, 3813 Folsom Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>4201</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Prostate</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from <b>1-4-63</b> to <b>9-17-63</b> and last saw her/him alive on <b>9-16-63</b> Death occurred at <b>12:05 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE (Degree or title) <b>Kenneth Price MD</b>		22b. ADDRESS <b>5600 Arsenal</b>		22c. DATE SIGNED <b>9-17-63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-19-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Keysville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Keysville, Mo.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Jonas Funeral Home, Steelville, Missouri.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 19 1963</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>				

USE BLACK INK OR TYPEWRITER RIBBON

SEP 26 1963

OCT 8 1963

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

*Stanley H. Dixon*

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.