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FILED MAR 6 1944 - 318
Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (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: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Poolidge, Robert Repard**
3. (b) If veteran, name war. **3. (c) Social Security** No. **1**

4. Sex **MALE** **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 **4** years
7. Birth date of deceased **OCTOBER 24, 1927**
(Month) (Day) (Year)

8. AGE: Years **16** Months **4** Days **2**
 If less than one day hr. min.

9. Birthplace **TARENTUM, PENNSYLVANIA**
(City, town, or county) (State or foreign country)

10. Usual occupation **SCHOOL**
11. Industry or business **SCHOOL**

MOTHER **FATHER**
12. Name **DON COOLIDGE**
13. Birthplace **CEDAR RUN, PENNSYLVANIA**
(City, town, or county) (State or foreign country)
14. Maiden name **ADELINE M. MOST**
15. Birthplace **MERCHANTVILLE, N**
(City, town, or county) (State or foreign country)

16. (a) Informant **Don Coolidge**
(b) Address **Crystal City, Mo.**
17. (a) Burial **(b) Date thereof** **Feb 29, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Crystal City, Mo.**

18. (a) Signature of funeral director **J. F. Bredeck**
(b) Address **Crystal City, Mo.**
19. (a) FEB 28 1944 **J. F. Bredeck**
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jefferson**
 (c) City or town **CRYSTAL CITY**
(If outside city or town limits, write "RURAL")
 (d) Street No. **B**
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country **NR.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **26**
 year **44** hour **6** minute **P** M.
21. I hereby certify that I attended the deceased from **Feb 23, 1944** to **Feb 26, 1944**
 that I last saw him alive on **Feb 26, 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute myelogenous leukemia**
 Duration **7 Hrs**
 Due to
 Due to
 Other conditions **(Include pregnancy within 3 months of death)**

Major findings:
 Of operations
 Of autopsy **Massive hemorrhage into gastro-intestinal tract**
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 **D**
23. Signature **A.C. Abney** (M. D. or other)
 Address **BARNES HOSPITAL** Date signed **2/26/44**

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..... *Geoffrey R. Polittle*

Licensed Embalmer No. *3481*

P. O. Address *Crystal City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.