

No. 2  
M-5-43  
5-17-39  
I X36571

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11695

State File No. ....

FILED MAY 12 1945

318

Registration District No. .... Primary Registration District No. .... 1003

Registrar's No. .... 3945

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
5174 Kensington  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... None  
(Specify whether

In this community..... 14 Years  
years, months or days)

3. (a) PRINT FULL NAME Sophia Robb

3. (b) If veteran, name war..... No

3. (c) Social Security No..... No

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife..... Unknown

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... Sept. 29 1854  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

90 7 4 hr. min.

9. Birthplace..... Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation..... House Wife

11. Industry or business..... At home

MOTHER FATHER { 12. Name..... John W Durham

{ 13. Birthplace..... Ireland  
(City, town, or county) (State or foreign country)

{ 14. Maiden name..... Joan Abbott

{ 15. Birthplace..... Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant..... Joseph True

(b) Address..... 5372 A Natural Bridge

17. (a) Motor (Burial, cremation, or removal) (b) Date thereof..... 5 / 5 / 45  
(Month) (Day) (Year)

(c) Place: burial or cremation..... Union Mo.

18. (a) Signature of funeral director..... A. W. McLaughlin

(b) Address..... 2301 Lafayette Ave.

19. (a) MAY 3 1945 (Date received local registrar) J. F. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000

(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No..... 5174 Kensington  
(If rural, give location)

(e) Citizen of foreign country?..... No (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... 5 day..... 3  
year..... 45 hour..... 1 minute..... 30 P-M.

21. I hereby certify that I attended the deceased from  
May 1 1945 to May 3 1945  
that I last saw him alive on May 2 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Chronic Myocarditis with Arteriosclerosis  
Duration

Due to..... 930

Due to.....

Other conditions..... Chronic Bronchitis  
(Include pregnancy within 3 months of death)

acute exacerbation

Major findings:  
Of operations.....

Of autopsy.....

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)..... No

(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

23. Signature..... A. B. [unclear] (M. D. or other)  
Address..... 4901 E. Easton Ave Date signed..... 5/3/45

**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 *L. B. Casper*.....

Licensed Embalmer No. *3633*.....

P. O. Address *2317 Lafayette*.....

**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.**