

FILED AUG 16 1947

Registration District No. 9600

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

29842  
State File No. \_\_\_\_\_  
Registrar's No. 1671

1. PLACE OF DEATH:  
(a) County: St. Louis  
(b) City or town: Koch (rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: 549 days  
(Specify whether years, months or days)  
In this community: 21 years  
years, months or days

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.: 1843 Kennett Place  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: ADDIE ATKINS  
3. (b) If veteran, name war: \_\_\_\_\_  
3. (c) Social Security No.: None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month: August day: 4  
year: 1947 hour: 11 minute: 03 P. M.

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Widow  
6. (b) Name of husband or wife: Edward Atkins 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years  
7. Birth date of deceased: September 5 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-1- 1946, to 8-4- 1947, that I last saw her alive on 8-4- 1947, and that death occurred on the date and hour stated above.

8. AGE: Years: 77 (?) Months: 10 Days: 29 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: (?) Pulmonary Tuberculosis  
Duration: 16 yr. ??

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

Due to: 136  
Due to: \_\_\_\_\_

10. Usual occupation: Nil

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

MOTHER FATHER:

11. Industry or business: \_\_\_\_\_  
12. Name: John Darden  
13. Birthplace: Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name: Sarah Friar  
15. Birthplace: Tennessee  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

16. (a) Informant: Hospital Records  
(b) Address: Robert Koch Hospital  
17. (a) BURIAL (b) Date thereof: Aug 7-47  
(Burial, cremation, or other) (Month) (Day) (Year)  
(c) Place: burial or cremation: St Matthews  
18. (a) Signature of funeral director: E. Schurr  
(b) Address: 3125 Lafayette Ave  
8-8-47  
19. (a) 8-8-47 (b) Robert J. Sharpe  
(Date received local registrar) (Registrar's signature)

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 plant, in public place? \_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury: 0  
23. Signature: Bernard Friedman (M. D. or other M.D.)  
Address: Robert Koch Hospital Date signed: 8-5-47

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Joseph B. Hollman*

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave 4*

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.