

No. 300
10. 45

FILED APR 3 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11139

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 648

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>KOCH</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS 225.9</u> | |
| c. LENGTH OF STAY (in this place) <u>109 days</u> | | d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROBERT KOCH HOSP.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROBERT KOCH HOSP.</u> | | e. STREET ADDRESS (If rural, give location) <u>25 BROADWAY & CLARK</u> | |

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|---|---------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or Print) <u>JACK</u> a. (First) <u>ROBERTSON</u> b. (Middle) <u>-</u> c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>MAR 3 1951</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SEP. (?)</u> | 8. DATE OF BIRTH <u>MAR. 25, 1887</u> | 9. AGE (In years last birthday) <u>63</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>? TENNESSEE</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME <u>DAVID ROBERTSON</u> | | 13b. MOTHER'S MAIDEN NAME <u>ELIZ. GARDNER</u> | | 14. NAME OF HUSBAND OR WIFE <u>MABLE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL CHART.</u> ADDRESS _____ | |

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|--|--|---|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH/ <u>UNKNOWN</u> | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PULMONARY TUBERCULOSIS</u> | | ANTECEDENT CAUSES | | | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (b) _____ | |
| | | | | DUE TO (c) _____ | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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>002X</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>0</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | |

22. I hereby certify that I attended the deceased from 1/3, 1951, to 3/3, 1951, that I last saw the deceased alive on 3/3, 1951, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

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|---|--|---|--|--|--|
| 23a. SIGNATURE <u>David Goldman, M.D.</u> (Degree or title) | | 23b. ADDRESS (Koch Hospital) <u>5-37 N. Grand St. Louis, Mo</u> | | 23c. DATE SIGNED <u>3/5/51</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal to</u> | | 24b. DATE <u>3-12-51</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Antonios</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>Logan Chris School</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Mortuary Service Inc.</u> ADDRESS _____ | | | |
| DATE REC'D BY LOCAL REG. <u>3-13-51</u> | | REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u> | | | |

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 at C.M.S.
working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *William H. Crawford*

Licensed Embalmer No. *04765*

P. O. Address *4937 West Park*

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.