

FILED JUL 3-1 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26263**
Registrar's No. **6532**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 26263		Registrar's No. 6532					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) 1 day		c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF (If not in hospital or institution give street address or location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 12 5117 Westminster		2127							
3. NAME OF DECEASED (Type or Print) a. (First) Robert			b. (Middle) Coit			c. (Last) Day			4. DATE OF DEATH (Month) (Day) (Year) 6 30 53				
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 7, 1870		9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-President				10b. KIND OF BUSINESS OR INDUSTRY Day Rubber Co.		11. BIRTHPLACE (City and State or Foreign Country) Stonington, Connecticut				12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Asa W. Day				13b. MOTHER'S MAIDEN NAME Mary Rebecca Coit.				14. NAME OF HUSBAND OR WIFE Catherine Morgan Day					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Catherine M. Day-5117 Westminster							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured abdominal aortic aneurysm ANTECEDENT CAUSES Morbid 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. Arteriosclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21f. HOW DID INJURY OCCUR? 451X							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 6-29 , 19 53 , to 6/30 , 19 53 , that I last saw the deceased alive on 6/30 , 19 53 , and that death occurred at 11:15 am. , from the causes and on the date stated above.									
23a. SIGNATURE F. Bradley (Degree or title) M. D.				23b. ADDRESS BARNES HOSPITAL				23c. DATE SIGNED 6/30/53					
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7-2-53		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri							
DATE REC'D BY LOCAL REG. JUL 1 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,							

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

JUL 31 19

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 *Clarence K. Murray*

Licensed Embalmer No. *401*

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.