

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **30931**BIRTH NO. **81048-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8676**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place) <b>15 min</b>		d. STREET ADDRESS (If rural, give location) <b>26 2921 N. 11th St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		e. DATE OF DEATH (Month) (Day) (Year) <b>10-2-1955</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Robert</b> b. (Middle) <b>Lynn</b> c. (Last) <b>Hankins</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>10-2-1955</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never</b>	8. DATE OF BIRTH <b>10-2-1955</b>
9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. HOURS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>James A. Hankins</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Belle Woolf</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>James A. Hankins</b>	
18. ADDRESS <b>2921 N. 11th St.</b>			

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>5 months premature</b> ANTECEDENT CAUSES DUE TO (b) <b>pre-natal uterine bleeding</b> DUE TO (c) <b>Separated placenta</b> II. OTHER SIGNIFICANT CONDITIONS <b>one of twins, the other stillborn.</b> <del>none</del>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>June 1955</b> <b>intervals to miscarria</b>
19a. DATE OF OPERATION <b>no</b>	19b. MAJOR FINDINGS OF OPERATION <b>761.5</b>		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)
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"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1:45 am, 1955**, to **2:00 am, 1955**, that I last saw the deceased alive on **2:00 am, 1955**, and that death occurred at **2:01 am**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Wm. S. Young M.D.</b>	23b. ADDRESS <b>1126 St. Louis Ave.</b>	23c. DATE SIGNED <b>10-4-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10-2-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Dexter, Mo.</b>
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	
DATE REC'D BY LOCAL REG. <b>OCT 4 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	(Licensed Embalmer's Statement on Reverse Side)

TO BE RETURNED TO THE BOARD OF HEALTH  
JUNE 1922

pre-arranged embalming

pre-arranged embalming

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. \_\_\_\_\_

GA

working under my personal supervision.

Student .....

Student Embalmer

Signed

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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

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