

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 274

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>																
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OVERLAND</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>OVERLAND 4390</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>														
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2129 N. WARSON</u>			Length of stay in 1b <u>4 YRS</u>		d. STREET ADDRESS <u>2129 N. WARSON</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>ROBERT LEE STAPLETON</u> First Middle Last				4. DATE OF DEATH <u>1-28-57</u> Month Day Year																
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 16 1980</u>		9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK LAYER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>										
13. FATHER'S NAME <u>JOHN ORSON STAPLETON</u>						14. MOTHER'S MAIDEN NAME <u>EMMA KIMBEL</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>489-05-6316</u>		17. INFORMANT Address <u>WARRENTON MO</u> <u>WM. ROBERT STAPLETON</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic cardiovascular disease</u> DUE TO (c) <u>Pulmonary emphysema, chronic 4221</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour - a.m. - p. m. Month, Day, Year			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		CITY		STATE	
21. I attended the deceased from <u>1956</u> to <u>time of death</u> and last saw <u>him</u> alive on <u>1-28-1957</u> Death occurred at <u>4:20 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.																				
22a. SIGNATURE <u>Fred C. Post, MD</u> (Degree or title)						22b. ADDRESS <u>2335 Burnside St. York Mo.</u>				22c. DATE SIGNED <u>1-29-57</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-31st 57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET PARK</u>				23d. LOCATION (City, town or county) (State) <u>St. Louis Co., Mo.</u>												
24. FUNERAL DIRECTOR <u>EARL WILKINSON OVERLAND MO</u>				25. DATE RECD. BY LOCAL REG. <u>1-30-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Donk</u>														

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No diagnosis will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

0503

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 *Emil J. Hillman*

Licensed Embalmer No. *350*

P. O. Address *Oxland*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.