

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11686

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 367

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	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay 23, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MaryRidge Nursing Home</u> Length of stay in 1b <u>2da</u>		16. STREET ADDRESS (If outside, give location) <u>3753 Gravois</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>E.</u> Last <u>Robison</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>8,</u> Year <u>1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 13, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 21 HRS.
11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hacker</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Roesner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>Unk.</u> 17. INFORMANT Address <u>Mrs. Helen Burgard 3753 Gravois</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>Chronic myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>4222</u>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
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	COUNTY STATE
21. I attended the deceased from <u>Feb 6</u> to <u>Feb 8</u> and last saw her alive on <u>Feb 7, 1957</u> Death occurred at <u>120a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John B. Campbell MD</u>		22b. ADDRESS <u>9625 Broadway</u>	22c. DATE SIGNED <u>2-8-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-11-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-8-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert A. Donker</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health,
Welfare
Public
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. securing the medical certification in the specific manner required by the law.

Dr. /Crawford

9612 S. Broadway

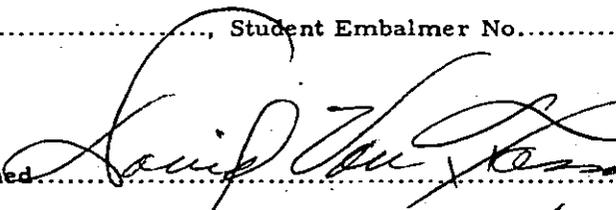
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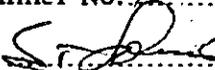
STATEMENT BY LICENSED EMBALMER

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.....


Licensed Embalmer No. 424

P. O. Address.....


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.