

Health,
& Welfare
Public
Service

S. 300
V. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms 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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 29 1957

15723

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 943

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>Northwoods</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Northwoods</u> <u>4150</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>6727 Daiber</u>			Length of stay in lb <u>4 1/2 yrs.</u>		d. STREET ADDRESS <u>6726 Daiber</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ALYCEAN</u> Middle <u>R.</u> Last <u>COLE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1928</u>		9. AGE (In years last birthday) <u>29</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Desloge Hosp.</u>		11. BIRTHPLACE (City and state or country) <u>Granite City, Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Hugh F. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Leona Robinson</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>492-24-9233</u>		17. INFORMANT <u>Hugh F. Robinson</u> Address <u>6727 Daiber</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>Acute Myocardial Infarction</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>✓</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7</u> <u>3</u>		
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>✓</u>						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>		COUNTY		STATE			
21. I attended the deceased from <u>January 1954</u> to <u>April 1957</u> and last saw her/him alive on <u>April 1st 1957</u> . Death occurred at <u>9:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Herbert B. Dombek</u> (Degree or title)				22b. ADDRESS <u>6701 Foster</u>		22c. DATE SIGNED <u>4-8-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 10, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>			
24. FUNERAL DIRECTOR <u>Pullan Kelly</u> ADDRESS <u>7267 Natural Bridge</u>				25. DATE RECD. BY LOCAL REG. <u>4-9-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Dombek</u>			

(Licensed Embalmer's Statement on Reverse Side)

89.

Earl Hicks

6301 Linton

6 to 8 PM

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 *James A. Lamme*

Licensed Embalmer No. 417

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.