

## STANDARD CERTIFICATE OF DEATH

37433

STATE FILE NUMBER

FILED NOV 15 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10005

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>25 City Hospital</b>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>21710 1655 S. Vandeventer</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>H.</b> Last <b>FORREST</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1888</b>		9. AGE (In years last birthday) <b>69</b>	F 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) <b>Machinist-Lambert</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tool Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert Forrest</b>			13b. MOTHER'S MAIDEN NAME <b>Amelia Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie Forrest</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>487-18-0916</b>	17. INFORMANT Address <b>Bessie Forrest 1655 S. Vandeventer</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Injury</b>						INTERVAL BETWEEN ONSET AND DEATH	
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). <b>Slipped when descending</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" 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 in 18.) <b>Fell from steps in home</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>10 45</b>		Date <b>October 4th 1957</b>					
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.) <b>17 Home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY <b>000</b> STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>225 P.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deputy or title) <b>Patrick Taylor</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>10-25-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct. 28, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>				ADDRESS	25. DATE RECD. BY LOCAL REG. <b>OCT 25 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 *William B. White* .....

Licensed Embalmer No. *4291* .....

P. O. Address *4228th Highway* .....

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.