

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3507

STATE FILE NUMBER

FILED JAN 13 1958

318

1003

Registrar's No. 152

Registration District No. Primary Registration District No.

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, give TOWNSHIP only) Inside Limits OR TOWN <b>St. Louis</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4133 Finney</b> Length of stay in lb <b>20 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>4133 Finney</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN R. ROBINSON</b> First Middle Last		4. DATE OF DEATH <b>1 8 58</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? 1889</b> Abt. 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>McCraken City, Tenn. U.S.A.</b>
13. FATHER'S NAME <b>Abe Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Charity ?????</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Altie Caldwell</b> Address <b>4133 Finney</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>Uremia-acidosis-Dehydration</b> DUE TO (b) <b>Prostatic hypertrophy.</b> DUE TO (c) <b>Coronary Artery Disease</b> PARTIAL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerosis-arteriosclerosis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12/1/57 to 1/5/58.</b>
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.) <b>610X</b>	
20c. TIME OF INJURY <b>Hour</b> <b>Month, Day, Year</b> 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 <b>St. Louis</b> COUNTY <b>St. Louis</b> STATE <b>Mo.</b>	
21. I attended the deceased from <b>1/5/58</b> and last saw her/him alive on <b>1/5/58</b> Death occurred at <b>8 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. Prophete MD</b> (Degree or title)		22b. ADDRESS <b>3136 Easton St. Louis, Mo</b>	22c. DATE SIGNED <b>1/6/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>1/10/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>Charles J. Gates</b> ADDRESS <b>4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 7 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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. 4580

P. O. Address .....4107 Fin

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.