

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-023685

STATE FILE NUMBER

FILED JUN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6099

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 1100 A. N. Leonard		d. STREET ADDRESS (If outside, give location) 219 1100 A. N. Leonard	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie Robinson			4. DATE OF DEATH Month Day Year 6 12 58
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1893
9a. AGE (In years last birthday) 64		9b. FUNDER 1 YEAR Months 7 Days 2	
9c. IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hillery Robinson	
13b. MOTHER'S MAIDEN NAME Georgia Russell		14. NAME OF HUSBAND OR WIFE Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Bettie Jean Champion		Address 1100 A. N. Leonard	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion			INTERVAL BETWEEN ONSET AND DEATH 4 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypostatic Pneumonia 356.1			1 day
DUE TO (c) Amyotrophic Lateral Sclerosis			1 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) Arteriosclerotic heart disease - Coriatic Insufficiency, Class II			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Eg. nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 12-6-57, to 6-12-58 and last saw her alive on 6-12-58 Death occurred at 11:55 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Henry C. Dugas M.D.		22b. ADDRESS 3186 Easton Ave. City 6.	
22c. DATE SIGNED 6-12-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 6-16-58		23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		24. FUNERAL DIRECTOR ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard	
25. DATE RECD. BY LOCAL REG. JUN 14 '58		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. a.e.m.	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Fulton E. Cull* .....

Licensed Embalmer No. *4198* .....  
P. O. Address *Albany* .....

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.