

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042739
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 549 Registrar's No. 3131
FILED DEC 10 1958

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webster Groves		c. CITY OR TOWN Webster Groves <i>4577</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 212 Newport		d. STREET ADDRESS (If outside, give location) 204 Newport	
Length of stay in lb YEARS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First EDWIN Middle B. Last ROBARDS			4. DATE OF DEATH Month November Day 27th , Year 1958		
---	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2nd, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 0 Days 25	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Real Estate	10b. KIND OF BUSINESS OR INDUSTRY Businessman	11. BIRTHPLACE (City and state or country) Henderson, Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
---	---	--	--

13a. FATHER'S NAME Edwin T. Robards	13b. MOTHER'S MAIDEN NAME UNK Bonbright	14. NAME OF HUSBAND OR WIFE Lallah Smith Robards
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. UNK	17. INFORMANT Mrs. Lallah Smith Robards	Address 204 Newport
--	---------------------------------------	---	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 11 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart (coronary) dis DUE TO (c) 4201		
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.)
---	--

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 St. Louis	COUNTY St. Louis	STATE Missouri
---	---	--	--	----------------------------	--------------------------

21. I attended the deceased from Aug 13 1959 , to Nov 27, 1959 and last saw her alive on Nov 26, 1959 Death occurred at 12:00 Noon m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Stanley W. Waad MD (Degree or title) M.D.	22b. ADDRESS 457 North Kingshighway	22c. DATE SIGNED 11/28/1958
---	---	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/29/1958	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
--	--------------------------------	--	--

24. FUNERAL DIRECTOR C. R. Lupton & Sons	ADDRESS 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. 11-28-59	26. REGISTRAR'S SIGNATURE Herbert R. Dombke MD
--	-------------------------------------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Vertical text on the left margin: All diseases in Part I must be causally related.

Mr. Edwin Kohardt

2:00 to 5:00 P.M.

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 *Arnold W. Schoen*

Licensed Embalmer No. *3864*
P. O. Address, *St. Louis, Mo.*

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.