

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045361

STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's 12075

300-3
-57

1. PLACE OF DEATH a. CITY OR TOWN St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Indianapolis	
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital DOA		d. STREET ADDRESS (If outside, give location) 1559 Bacon	
3. NAME OF DECEASED (Type or print) First Robert Middle Edward Last Alstott		4. DATE OF DEATH Month December Day 13 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 June 14, 1922
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Indianapolis, Indiana.
10c. FATHER'S NAME Thomas Edward Alstott		13b. MOTHER'S MAIDEN NAME Bertha B. Brown	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes N.W. # 2		16. SOCIAL SECURITY NO.	17. INFORMANT Address Edith Mae Alstott, 1559 Bacon, Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of the Skull; DUE TO (b) Subdural Hemorrhage of the Brain DUE TO (c) E902.6 45		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the immediate cause (a) Chaplain in full uniform		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. DESCRIIBE HOW INJURY OCCURRED, name of injury, PART I (a) at the La Salle Hotel, 508 Chestnut Street, about 10:08 am.		
20c. TIME OF INJURY Hour 10:08 a.m. Month, Day, Year December 13, 1958	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, pdlg., etc.) La Salle Hotel		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION St. Louis Mo COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 115A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Patrick Taylor Carauer 3		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 12.15.58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. 12-13-58	23c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	23d. LOCATION (City, town, or county) (State) Indianapolis, Indiana
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. DEC 15 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Oliver P. Sadwell*

Licensed Embalmer No. *4099*

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.