

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003170

STATE FILE NUMBER

830

FILED FEB 16 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
-57
9
3

| | | | | | |
|---|------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY <i>ST. LOUIS</i> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <i>4138 JENNINGS, MO.</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>MO. BAPTIST HOSP.</i> | | Length of stay in 1b <i>3 DAYS</i> | d. STREET ADDRESS (If outside, give location) <i>1918 HILDREDAVE</i> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>ROBERT</i> Middle _____ Last <i>KOLBE</i> | | | 4. DATE OF DEATH Month <i>JAN.</i> Day <i>23</i> Year <i>1959</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>JULY 13, 1873</i> | | 9. AGE (In years last birthday) <i>85</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED WOODWORKER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>UNKNOWN</i> | | 11. BIRTHPLACE (City and state or country) <i>ST. LOUIS, MO.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13a. FATHER'S NAME <i>UNK. KOLBE</i> | | 13b. MOTHER'S MAIDEN NAME <i>UNK. ZOBEL</i> | |
| 14. NAME OF HUSBAND OR WIFE <i>CLARA KOLBE</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>492-03-4494</i> | |
| 17. INFORMANT <i>CLARA KOLBE</i> | | Address <i>1918 HILDREDAVE, JENNINGS, MO.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Decompensation</i> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) <i>Arteriosclerotic Heart Disease.</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> | |
| DUE TO (c) <i>Severely Arteriosclerosis</i> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Ch. Dearden - Muscular Type (Heme)</i> | | 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.) <i>420.0</i> | | | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 | | COUNTY STATE | |
| 21. I attended the deceased from <i>Oct 23 1958</i> to <i>Jan 23 1959</i> and last saw him alive on <i>Jan 23 1959</i> Death occurred at <i>4PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>Robert W. Crossman M.D.</i> | | | 22b. ADDRESS <i>607 N. Grand Ave</i> | | 22c. DATE SIGNED <i>1/24/59</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | 23b. DATE <i>JAN. 26, 1959</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>NEW BETHLEHEM</i> | | 23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS COUNTY, MO.</i> |
| 24. FUNERAL DIRECTOR <i>SUEB MEYER SONS</i> | | ADDRESS <i>3934 N. 20TH ST.</i> | | 25. DATE RECD. BY LOCAL REG. <i>JAN 26 '59</i> | 26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i> <i>m80</i> |

(Licensed Embalmer's Statement on Reverse Side)

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 *Harvey Kable*
Licensed Embalmer No. *4591*
P. O. Address, *Floissant*

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.