Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003751
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 317 Primary Registration District No. 54 Registrar's No. 213

1. PLACE OF DEATH
a. COUNTY ST LOUIS COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST LOUIS COUNTY HOSP. — Length of stay in 1b 2 DA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY ST. LOUIS
c. CITY OR TOWN KINLOCH 409½ — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 103H SCUDDER — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Ben Middle Last Robinson

4. DATE OF DEATH Month 1 Day 18 Year 59

5. SEX MALE 2

6. COLOR OR RACE NEGRO

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH UNKNOWN ABOUT 63

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POTER

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (City and state or country) ALA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME SYLVESTER ROBINSON

13b. MOTHER'S MAIDEN NAME ROSETTA UPCHURCH

14. NAME OF HUSBAND OR WIFE MARY ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 421.07.0744

17. INFORMANT WILLIE LEE HUTTON — Address 1021 SCUDDER ST

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CEREBRAL HEMORRHAGE
DUE TO (c) HYPERTENSION. 33½
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 1-17-59, to 1-18-59 and last saw him alive on 1-18-59
Death occurred at 12:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE N B Kelly (Degree or title) M.D.

22b. ADDRESS 601 So. Brentwood

22c. DATE SIGNED 1-18-59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE 1-26-59

23c. NAME OF CEMETERY OR CREMATORY HOPEWELL CEMETERY

23d. LOCATION (City, town, or county) GREEN COUNTY (State) ALA

24. FUNERAL DIRECTOR PRICE BENEVOLENT ORDER OF FRIEND — ADDRESS 2829 WASHINGTON AVE

25. DATE RECD. BY LOCAL REG. 1-23-59

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Edward G. Flynn

Licensed Embalmer No. 4444

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.