

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007292

STATE FILE NUMBER

2 2069

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

Health, Welfare, Public Service
300
-56
17
179 3
0
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Disease in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Walton Home</u>		Length of stay in 1b <u>6 months</u>	d. STREET ADDRESS (If outside, give location) <u>1919 S. Grand Blvd</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>B.</u> Last <u>Karn</u>			4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>59</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1871</u>
9. AGE (In years last birthday) <u>87</u>		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) <u>Seed Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (City and state or country) <u>Belle Rive, Ill /</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Edward Karn</u>	
14. MOTHER'S MAIDEN NAME <u>Aminda Lewis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mae Boyle Karn 1919 S. Grand (wife)</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>420.1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
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 _____ 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 <u>Feb. 8, 1959</u> to <u>Feb. 27, 1959</u> and last saw ^{her} him alive on <u>2-24-59</u> . Death occurred at <u>8:50 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert B. Anderson, M.D.</u> (Degree or title)		22b. ADDRESS <u>1502 Cass Av</u>	22c. DATE SIGNED <u>2-27-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mt Vernon, Illinois</u>
24. FUNERAL DIRECTOR <u>Meyer Funeral Home Mt. Vernon, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 27 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

mb

1502 340

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
E. J. Pennington

Licensed Embalmer No.
42

P. O. Address.....
St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.