

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011321

STATE FILE NUMBER

2 2137

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. Phillips</b>		Length of stay in lb <b>34 yrs.</b>	
d. STREET ADDRESS <b>1222a Armstrong</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES ROBBIE</b>			4. DATE OF DEATH Month Day Year <b>Feb. 27, 1959</b>
5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1864</b>
9. AGE (In years last birthday) <b>84</b>	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) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and state or country) <b>Alamo, Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13a. FATHER'S NAME <b>Sam Robie</b>		13b. MOTHER'S MAIDEN NAME <b>Emmeline Barken</b>	
14. NAME OF HUSBAND OR WIFE <b>Nannie Robie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT Address <b>Leanna Harris Jackson, Tennessee</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause lost. } DUE TO (b) _____ DUE TO (c) _____			<b>331 X</b>
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"/> <b>2.</b>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> WORK 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 _____ and last saw her/him alive on _____ Death occurred at <b>300 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James H. Finney 3</b>		22b. ADDRESS <b>L300 Clark</b>	
22c. DATE SIGNED <b>3/2/59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3/2/59</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Jackson, Tennessee</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Gates 4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 2 '59</b>	
26. REGISTRAR'S SIGNATURE <b>Ward Smith, M.D.</b>			

300  
1-57  
38  
291  
6

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 *Gupton Swase* .....

Licensed Embalmer No. 4580 .....

P. O. Address 4107 Finney Avenue

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.