

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011327  
STATE FILE NUMBER  
2 2323

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

FILED MAR 30 1959  
PLACE OF DEATH

a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jennings 4137</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Little Rock Hospital Inc.</b>		d. STREET ADDRESS <b>8607 Henry Ave.</b>	Length of stay in lb <b>2 1/2 weeks</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Tom</b> Middle <b>-</b> Last <b>Robinson</b>	4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1959</b>
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5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Penstr. Switchman</b>	10b. KIND OF BUSINESS OR OCCUPATION <b>Terminal Railroad</b>	11. BIRTHPLACE (City and state or country) <b>England 4</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John Robinson</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Griffenwaite</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Robinson</b>
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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>None</b>	17. INFORMANT <b>Mrs. Mary Robinson, 8607 Henry A. ve.</b>
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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>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>420.1</b>		
DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Secondary Bacterial Peritonitis</b>		

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>Feb. 15, 1959</b> to <b>March 5, 1959</b> and last saw her alive on <b>5-3</b> Death occurred at <b>8:45 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD 0</b>	22b. ADDRESS <b>1755 S. Grand Ave.</b>	22c. DATE SIGNED <b>3-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>March 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County</b>	(State) <b>Missouri</b>
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24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc.</b>	ADDRESS <b>St. Louis, Mo. 2161 E. Fair Avenue</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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(Continued on Reverse Side)

Health, Welfare, Public Service  
300  
1-57  
All diseases in Part I must be causally related.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *Walter B. Beasley* .....

Licensed Embalmer No. *4302* .....

P. O. Address *St. Louis, Mo.* .....

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.