

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034735

FILED OCT 13 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2617 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis.</b>				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. Anns, Mo.</b>		Length of stay in 1b <b>YRS</b>		c. CITY OR TOWN <b>St. Anns.</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>11022 Bernice</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>11022 Bernice</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Lucinda</b> Middle <b>Robertson</b> Last <b>Robertson</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>2</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/30/1873</b>		9. AGE (last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Boone County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>William Poore</b>				13b. MOTHER'S MAIDEN NAME <b>Alice Scott</b>				14. NAME OF HUSBAND OR WIFE <b>John</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>Nil.</b>		17. INFORMANT Address <b>William Pullis, 11022 Bernice, St. Anns, Mo.</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>Congestive heart failure</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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.		Month, Day, Year											
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 <b>May 21 1959</b> to <b>Oct 2 1959</b> and last saw her/him alive on <b>Oct 2 1959</b> Death occurred at <b>12:20 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>R. N. Strodt D.O.</b>				22b. ADDRESS <b>8367 Olive St. Rd.</b>				22c. DATE SIGNED <b>10-2-59</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-5-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) <b>Centralia, Mo.</b>		(State)					
24. FUNERAL DIRECTOR <b>Meador Funeral Home, Centralia, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10-2-59</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SA JUN 16 1960

STATEMENT BY LICENSED EMBALMER

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

Student \_\_\_\_\_ Signature of Student Embalmer

Signed John Haines Licensed Embalmer No. 14108 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.