

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042803

FILED VS NOV 30 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2708

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5876 Kennerly Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ZETTA</u> Middle _____ Last <u>ROBERTSON</u>			4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/1900</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Section Gang</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo.-Pac. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>Augusta, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>William Robertson</u>		13b. MOTHER'S MAIDEN NAME <u>Susan ?</u>		14. NAME OF HUSBAND OR WIFE <u>Matlean Robertson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>498-09-0987</u>		17. INFORMANT Address <u>Matlean Robertson 5876 Kennerly</u>		
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>Unknown Natural Causes</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>7954</u>					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) _____					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ 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 _____ to _____ and last saw her/him alive on _____. Death occurred at <u>8:48 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John C. Murphy MD Asst. Health Commissioner</u>				22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>		22c. DATE SIGNED _____
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/16/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Charles J. Gates 4107 Finney</u>			25. DATE RECD. BY LOCAL REG. <u>10-13-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Gupton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Fern

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