

R I DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

~~CONFIDENTIAL~~

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 1835** — **60-008286** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5103 Waterman, Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otho Middle Last Robinette				4. DATE OF DEATH Month February Day 15, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/18/1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Auto Parts		11. BIRTHPLACE (City and state or country) Lesterville, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph Robinette			13b. MOTHER'S MAIDEN NAME Ella Smith		14. NAME OF HUSBAND OR WIFE Della Robinette		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT Della Robinette, 5103 Waterman, Ave.		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) Bronchogenic Carcinoma						INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) 162.1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral metastases, Emphysema, Heart failure						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 checked="" 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 _____ 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 Lesterville, Mo.		COUNTY STATE	
21. I attended the deceased from June 27, 1959 to Feb. 15, 1960 and last saw him alive on February 14, 1960 Death occurred at 10:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) David P. Kers, MD				22b. ADDRESS 950 Francis Pl. Clayton, Mo		22c. DATE SIGNED 2-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-18-60	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) Lesterville, Mo.		(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.				25. DATE RECD. BY LOCAL REG. FEB 17 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

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 Harvey Kable

Licensed Embalmer No. 4596

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.