

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, MISSOURI		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1112 South Compton	

3. NAME OF DECEASED (Type or print) First ROBERT Middle NMN Last BISHOP			4. DATE OF DEATH Month AUGUST Day 26 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/3/1921	9. AGE (last birthday) 39	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	10b. KIND OF BUSINESS OR INDUSTRY Army Record Center	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Willie Bishop	13b. MOTHER'S MAIDEN NAME Lucinda Doss	14. NAME OF HUSBAND OR WIFE Lucinda Bishop	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes NW 11	16. SOCIAL SECURITY NO. 491-12-5587	17. INFORMANT Address Mrs. Lucinda Bishop--1112 South Compton
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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:		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE MINUTES
IMMEDIATE CAUSE (a) CARDIAC ARREST		
DOE TO (b) HYPOTHERMIA AND ANOXIA		
DOE TO (c) 330X		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) SUBARACHNOID HEMORRHAGE DUE TO ANEURYSM OF ANTERIOR COMMUNICATING ARTERY		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **AUG. 24, 1960** to **AUG. 26, 1960** and last saw her/him alive on **AUG. 26, 1960**
 Death occurred at **12:55 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. V. Bradley M.D. M. D.	(Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/27/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/1/60	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR E. B. France	ADDRESS 1221 North Grand Blvd.	25. DATE RECD. BY LOCAL REG. AUG 29 1960	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Additional address: 5121

Additional address

SS (S)

certified

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 Melvin Blackman

Licensed Embalmer No. 3962
P. O. Address 122' N 10'

Note: The above ~~MUST BE~~ **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.