

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034851

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8212

AMENDED FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>2 Days</u>	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cardinal Glennon Memorial Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>4490 Laclede</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>Lynne</u> Last <u>Robertson</u>			4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-2-61</u>	9. AGE (last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Festus, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>Huey Robertson</u>	13b. MOTHER'S MAIDEN NAME <u>Betty Kent</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Huey Robertson, 4490 Laclede</u>
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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) <u>Abnormal Pulmonary Ventilation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <u>(immaturity) premature.</u> DUE TO (b) _____ DUE TO (c) <u>762.5</u>		INTERVAL BETWEEN ONSET AND DEATH
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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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT, SUICIDE, HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Sept 2, 1961 to Sept 4, 1961 and last saw her/him alive on Sept 4, 1961
Death occurred at 9:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Richard E. Cannon, M.D.</u>	22b. ADDRESS <u>Cardinal Glennon Hosp.</u>	22c. DATE SIGNED <u>9/4/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hercyaneum</u>	23d. LOCATION (City, town, or county) (State) <u>Hercyaneum Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Vinyard Funeral Home, Festus, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 5 1961</u>	26. REGISTRAR'S SIGNATURE <u>Keal Smith, M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 9/2
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald H. Vinyard

Licensed Embalmer No. 460P

P. O. Address Festus, 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.