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 SEE CERTIFIED DECKER FOR MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 189
 Registrar's No. 189

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1008
 (a) County _____
 (b) City or town St. Louis, Missouri
 (c) Name of hospital or institution: City Hospital, #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Days
 (Specify whether years, months or days)
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO. (b) County 1
 (c) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7138 LANHAM AV.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Robert Atkins on 325
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex MALE **5. Color or race** WHITE **6. (a) Single, widowed, married, divorced** SINGLE
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
7. Birth date of deceased. APR 10 1847
 (Month) (Day) (Year)

8. AGE: Years 92 Months 8 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MO
 (City, town, or county) (State or foreign country)

10. Usual occupation CARPENTER

11. Industry or business
MOTHER FATHER
12. Name E. W. ATKINSON
13. Birthplace MD.
14. Maiden name SARAH RODGERS
15. Birthplace NEN JERSEY
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. Hutchinson
(b) Address 5592 BARTMER

17. (a) BURIAL (b) Date thereof 1-10-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation BELLEFOUNTAIN CEM

18. (a) Signature of funeral director Dr. J. Croghan
(b) Address 7146 MANCHESTER

19. (a) Jan 8 - 40 (b) J. F. Bruck
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6, year 1940 hour 3:10 minute _____ P. A. M.
21. I hereby certify that I attended the deceased from January 5, 1940, to January 6, 1940;
 that I last saw h im alive on January 6, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerotic Heart Disease
Duration _____

Due to _____
Due to _____
Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
Of autopsy _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) **(e) Means of injury** _____

23. Signature J. F. Bruck **(M. D. or other)** _____
Address 1515 Lafayette, **Date signed** 1/8/40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.