

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether \_\_\_\_\_)  
In this community Lifetime  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1401 Newhouse Ave  
Memorial (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st  
year 1948 hour 4 minute 00 P. M.  
21. I hereby certify that I attended the deceased from 4/17/48  
to June 1st 1948  
that I last saw her alive on June 1st 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Cardiac failure  
Due to Arteriosclerotic Heart Disease  
Due to g.s.w.  
Other conditions: Mid thigh Amputation  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations None  
Of autopsy None

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 C. G. Luer M.B.O.  
1515 Lafayette 6/2/48 or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME CARRIE ROBBINS

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Eugene Robbins 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased December 19 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 5 12 hr. min.

9. Birthplace St. Louis MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name William Bierman

13. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unk. Koeheman  
(City, town, or county) (State or foreign country)

15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Eugene Robbins (Son)

(b) Address 3434a N. 19 Street

17. (a) Burial (b) Date thereof 6/4/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Suedmeyer & Sons

(b) Address 3934 N. 20 Street

19. (a) JUN 3 1948 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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.....

*Neville D. Thoburn*

Licensed Embalmer No. 3696

P. O. Address 3934 No 20th St

**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, fact should be so stated above.**