

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21389

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5592

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY oao	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 47	c. CITY OR TOWN St. Louis 17 1/2	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4327 <sup>1/2</sup> Cook Ave		d. STREET ADDRESS (If rural, give location) 11-4327 <sup>1/2</sup> Cook	

3. NAME OF DECEASED (Type or Print) Robert	a. (First)	b. (Middle) M <sup>c</sup> Nairy	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) June 24 1949
--	------------	----------------------------------	-----------	--

5. SEX 2 Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 19, 1876	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Hours 5
---------------	------------------------	--	--------------------------------	------------------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Porter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pulaski, Tenn. /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	-------------------------------------

13a. FATHER'S NAME Robert M <sup>c</sup> Nairy, Sr.	13b. MOTHER'S MAIDEN NAME Flora Harris	14. NAME OF HUSBAND OR WIFE Della M <sup>c</sup> Nairy
---	--	--

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. 709-10-2136	17. INFORMANT'S SIGNATURE OR NAME Della M <sup>c</sup> Nairy	ADDRESS
---	-------------------------------------	--	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH about 6 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis arterio-scleriosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic asthma.		6 years	

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-----------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ✓	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4202 <sup>1/2</sup>
--	--	--

22. I hereby certify that I attended the deceased from May 16, 1949, to June 6, 1949, that I last saw the deceased alive on June 6, 1949, and that death occurred at 6 a. m., from the causes and on the date stated above.

23a. SIGNATURE Dr. W. O. Loeschner M.D.	(Degree or title)	23b. ADDRESS 3904 Laclede Ave	23c. DATE SIGNED June 25 1949
---	-------------------	-------------------------------	-------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6/29/49	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
---	-------------------	--	---

DATE REC'D BY LOCAL REG. JUN 27 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4469
--------------------------------------	------------------------------------	---

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

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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Frederick P. Stark.....

Licensed Embalmer No. 4459.....

P. O. Address St. Louis.....

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.