

S. No. 300
10.48
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28919

State File No.

FILED AUG 17 1949

BIRTH NO. _____ REG. DIST. NO. 1317 PRIMARY REG. DIST. NO. 16776 Registrar's No. 1875

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>	c. LENGTH OF STAY (in this place) <u>1</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>127 E. Cartwright</u>		d. STREET ADDRESS (If rural, give location) <u>127 E. Cartwright</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JENNIE</u>	b. (Middle) <u>C.</u>	c. (Last) <u>ROBERTSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 1, 1949</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 17, 1895</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u>	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Simpson, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Wm. H. Anderson</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Veach</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Robertson</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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Charles Robertson-127 E. Cartwright</u>	ADDRESS <u>127 E. Cartwright</u>
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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 <u>1/201</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 7/31, 1949 to Aug 1, 1949, that I last saw the deceased alive on Aug 1, 1949, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Walter T. M.D.</u>	23b. ADDRESS <u>7110 Michigan</u>	23c. DATE SIGNED <u>8/3/49</u>
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/5/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-3-49</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Alinsky, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Kriegshauser</u>	ADDRESS <u>4228 S. Kingshighway Bl.</u>
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(Licensed Embalmer's Placement on Reverse Side)

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

PS.

72 2-5897

OCT 22 1949

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 Richard W. Storrsand

Licensed Embalmer No. 4007

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, fact should be so stated above.