

FILED MAY 4 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14645

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3941**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis OR TOWN 2079	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4952 Ashby Street.,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print) DOROTHY	a. (First)	b. (Middle)	c. (Last) ROBBINS	4. DATE OF DEATH (Month) (Day) (Year) APRIL 24 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 10, 1882	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Mulcahey	13b. MOTHER'S MAIDEN NAME Ann Stebbin	14. NAME OF HUSBAND OR WIFE Samuel Robbins
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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) No Nil	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Queenie Keane	ADDRESS 4932 Hooke Street.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 332X
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22. I hereby certify that I attended the deceased from **4-1-51**, 19___, to **4-24-51**, 19___, that I last saw the deceased alive on **4-24-51**, 19___, and that death occurred at **5:40P.** m., from the causes and on the date stated above.

23a. SIGNATURE R. Keane M.D. (Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 4-25-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-28-51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE RECD BY LOCAL REGISTRAR'S SIGNATURE APR 26 1951 J. B. Lester	25. FUNERAL DIRECTOR'S SIGNATURE Harrigan-Sheahan	ADDRESS 4700 Washington Blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *me*

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *W. W. Wilkinson*

Licensed Embalmer No. *3575*

P. O. Address *St. Louis 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 this body is not embalmed, fact should be so stated above.