

FILED JUN 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18772
Registrar's No. 4788

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
c. LENGTH OF STAY (In this place) 2 yr-11 mo		d. STREET ADDRESS (If rural, give location) 5400 Arsenal St	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Robert		b. (Middle) Yarbrough	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) May 19 1951	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 8-11-10
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months 10	IF UNDER 11 HRS. Days 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Terrell, Texas
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME William Yarbrough		13b. MOTHER'S MAIDEN NAME Eula May Kinsey	
14. NAME OF HUSBAND OR WIFE			
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. no	
17. INFORMANT'S SIGNATURE OR NAME William Yarbrough, 91-1 S. Bwdy.		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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Organic Brain Disease ANTECEDENT CAUSES DUE TO (b) Pneumonia DUE TO (c) Anemia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Epilepsy with psychotic episodes.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 3533	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 30 X			
22. I hereby certify that I attended the deceased from June 19 1951, to May 19, 1951, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:35 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John Schlenker, M.D.		23b. ADDRESS 5400 Arsenal St.	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 5/23/51	
24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.	
DATE REC'D BY LOCAL REG. MAY 22 1951		REGISTRAR'S SIGNATURE J. B. Laster	
25. FUNERAL DIRECTOR'S SIGNATURE Fendler Und.		ADDRESS 7420 Michigan Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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

Gustav W. Dietrich

Licensed Embalmer No. *4329*

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.