

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23400**

FILED JUN 26 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **548** Registrar's No. **1690**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Webster Groves</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Webster Groves</b>	
c. LENGTH OF STAY (In this place) <b>30 Yrs</b>		d. STREET ADDRESS (If rural, give location) <b>300 Reavis <del>Pl.</del> Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>300 Reavis Place</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>WILSON</b>	b. (Middle) <b>ABBOT</b>	c. (Last) <b>ROBINSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>6-16-1953</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4-16-1886</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months	IF UNDER 2 Wks. Days	IF UNDER 24 Hrs. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Correspondent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery Ind.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Anchorage Ky.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Orlando D. Robinson</b>	13b. MOTHER'S MAIDEN NAME <b>Celestia Weeks</b>	14. NAME OF HUSBAND OR WIFE <b>Adele Robinson</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Adele Robinson</b>	ADDRESS <b>300 Reavis Pl.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6-16-53</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Heart Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>		
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 <b>4201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>	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?
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22. I hereby certify that I attended the deceased from **6-16-1953** to **6-16-1953**, that I last saw the deceased alive on **6-16-1953**, and that death occurred at **9:15** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Carl G. Smith M.D.</b> (Degree or title)	23b. ADDRESS <b>Webster Groves Mo.</b>	23c. DATE SIGNED <b>6-16-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-19-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Kirkwood Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6-18-53</b>	REGISTRAR'S SIGNATURE <b>Harriet R. Dombrowski</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Home Webster Groves Mo.</b>	ADDRESS
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(Licensed Practitioner'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 \_\_\_\_\_

*Leslie Welch*

Licensed Embalmer No. \_\_\_\_\_

4395

P. O. Address \_\_\_\_\_

*Wabster Ground*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.