

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13194

State File No.

318

1003

3508

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Missouri b. COUNTY Jefferson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		c. CITY OR TOWN Festus	
		e. STREET ADDRESS (If rural, give location) 213 S. Adams St.	

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) (NMN)	c. (Last) BLAND	4. DATE OF DEATH (Month) (Day) (Year) April 16, 1954
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 10, 1887	9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glasswork	10b. KIND OF BUSINESS OR INDUSTRY P.F.G.Co.	11. BIRTHPLACE (City and State or Foreign Country) Washington Co., Mo.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Clara Mae Casey ADDRESS Festus, Missouri

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease 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 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) H16 X
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?

22. I hereby certify that I attended the deceased from April 5, 1954, to April 16, 1954, that I last saw the deceased alive on April 16, 1954, and that death occurred at 2:45 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. J. Dornellin M.D.	23b. ADDRESS Barnes Hospital	23c. DATE SIGNED 4-16-54
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 4-21-54	24c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery
		24d. LOCATION (City, town, or county) (State) Festus, Missouri

DATE REC'D BY LOCAL REG. APR 19 1954	REGISTRAR'S SIGNATURE Cash Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Gentry R. Politte ADDRESS Crystal City, Mo.
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(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.....
Signature of Student Embalmer

Signed *Gentry R Politt*.....

Licensed Embalmer No. *348*.....

P. O. Address *Unpla*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.