

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35519  
STATE FILE NUMBER  
9074  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthonys Hosp.</b> Length of stay in lb		STREET ADDRESS <b>5242a Genevieve Ave.</b> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>E.</b> Last <b>FRENCH</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>3</b> Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 13, 1927</b>
9. AGE (In years less birthday) <b>29</b>	IF UNDER 1 YEAR Months <b>29</b> Days <b>0</b> Hours <b>0</b> Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) <b>Tryon, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore French</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.11</b>		16. SOCIAL SECURITY NO. <b>505-22-9989</b>	
17. INFORMANT <b>Mrs. Mary French 5242a Genevieve Ave.</b>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Tracheobronchitis</b> <b>Lobar Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Post Poliomylitis - Bulbar 1953</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <b>081X</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>11:15</b> Month, Day, Year <b>11 12</b> a. m. <b>11</b> p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>June 1953</b> to <b>Oct 3, 1956</b> and last saw <b>her</b> alive on <b>10-2-56</b> Death occurred at <b>11:15 AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Joseph E. Carney MD</b>		22b. ADDRESS <b>906 Olive</b>	
22c. DATE SIGNED <b>10-4-56</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/6/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 4 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>

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 *J. M. Ruster*.....

Licensed Embalmer No. *390*

P. O. Address *St. Louis*

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.