

STANDARD CERTIFICATE OF DEATH

30097

STATE FILE NUMBER

FILED SEP 4 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8006

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 2197 1/2 325 N. Newstead Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
38 FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 6th. & Cole Sts.		Length of stay in lb		4. DATE OF DEATH August 24, 1957	
3. NAME OF DECEASED (Type or print) First Middle Last Beulah Josephine Tobin		4. DATE OF DEATH August 24, 1957		Month Day Year	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1893	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months Days Hours Min. 0 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) Fur Dept. Stix-Baer & Fuller		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) Fur Dept. Stix-Baer & Fuller		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME William Joseph Tobin		13b. MOTHER'S MAIDEN NAME Margaret MCCoy		14. NAME OF HUSBAND OR WIFE Mrs. New Robinson 325 N. Newstead	
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. 488-05-6074		17. INFORMANT Address Mrs. New Robinson 325 N. Newstead	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE				INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO: (b) ARTERIOSCLEROTIC HEART DISEASE				10 yrs.	
DUE TO: (c)					
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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT. SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.0			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 9/6/57 to 8/24/57 and last saw her alive on 8/17/57 3:30 pm. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Norman W. Gray (Degree or title) med		22b. ADDRESS 634 N. Grand		22c. DATE SIGNED 8/26/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 29, 1957		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 29, 1957		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)			
24. GENERAL DIRECTOR J. Paul Donnelly per Harry Green MD		25. DATE RECD. BY LOCAL REG. AUG 27 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD S.P.	
Licensed Embalmer's Statement on Reverse Side					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Francis Williams*

Licensed Embalmer No. *356*
P. O. Address *3840 Lin*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.