

r. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030902

STATE FILE NUMBER

FILED SEP 15 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's

8221

S. 300  
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY St. Louis                              |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Pagedale 4281   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Luke's Hosp  |  | Length of stay in 1b<br>Life  | d. STREET ADDRESS (If outside, give location)<br>1601 Faris Ave         |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Emma Wilhemina Robinson   |  | 4. DATE OF DEATH<br>Month Day Year<br>Aug. 21, 1958   |   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Jan. 7, 1869  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   | 9. AGE (In years last birthday)<br>89                                   |
| 11. BIRTHPLACE (City and state or country)<br>St. Louis, Missouri   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 13a. FATHER'S NAME<br>William Petering  |  | 13b. MOTHER'S MAIDEN NAME<br>Henrietta Flick  | 14. NAME OF HUSBAND OR WIFE<br>John F. Robinson                         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No None  |  | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT Address<br>Mr John F. Robinson 1601 Faris Ave             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of ascending colon</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) <u>1530</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 mo</u>                         |
| 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.)<br><u>2</u>  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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 <u>4/5/58</u> to <u>5/21/58</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>5/21/58</u><br>Death occurred at <u>St. Luke's Hosp</u> on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>Her Mother</u>   |  | 22b. ADDRESS<br><u>3720 Washington St. Louis Mo.</u>  | 22c. DATE SIGNED<br><u>8/23/58</u>                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal  | 23b. DATE<br>8/25/58   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Grove Cemetery  | 23d. LOCATION (City, town, or county) (State)<br>St. Louis Co, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS<br>Alexander & Sons 6175 Delmar Bl   |  | 25. DATE RECD. BY LOCAL REG.<br>AUG 25 '58  | 26. REGISTRAR'S SIGNATURE<br><u>J. Carl Smith, M.D.</u>                 |

(Licensed Embalmer's Statement on Reverse Side)

Dr.H.W.Noller  
3720 Washington Blvd  
Je.3-8498  
Sat. 9 to 11 A.M.

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 *Jos. E. McCulloch* .....

Licensed Embalmer No. *2760* .....

P. O. Address *617 6th Ave* .....

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.