

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007580

STATE FILE NUMBER

2166

FILED MAR 10 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registr. No. \_\_\_\_\_

300

-57

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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 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>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2230 Franklin</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alex</b> Middle <b>Robinson</b> Last <b>Robinson</b>			4. DATE OF DEATH Month <b>3</b> Day <b>1</b> Year <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>3/18/09</b>	9. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lake County Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13a. FATHER'S NAME <b>Unk</b>		13b. MOTHER'S MAIDEN NAME <b>Unk</b>		14. NAME OF HUSBAND OR WIFE <b>Altes Robinson</b>	
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>Unk</b>	17. INFORMANT <b>Altes Robinson</b> Address <b>2230 Franklin Ave</b>			
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>Uremia</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Probable Chronic Renal Disease</b>					undet.
DUE TO (c) <b>592x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive Cardiovascular Disease - Hypertension</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>2-21-59</b> , to <b>3-1-59</b> and last saw <sup>him</sup> <b>3-1-59</b> alive on Death occurred at <b>8:15</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A. D. Mann</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>2601 Whittier Street</b>		22c. DATE SIGNED <b>3-2-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandhill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>New Madrid Mo.</b>	
24. FUNERAL DIRECTOR <b>Richards</b> ADDRESS <b>New Madrid Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 2 '59</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

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

*Flannery M. Belt*

Licensed Embalmer No. 4375

P. O. Address *St. Louis, MO*

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.