

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015621

STATE FILE NUMBER

FILED MAY 6 1959

Registration District No.

Primary Registration District No.

Registration No. 3727

300
-57

9
3

0

300
-57
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3
0
Quinlan Park

Entered Hospital 5:10 pm 4/10/59
All diseases in Part I must be causally related.
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 Missouri 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"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 615 Walnut St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle Last ROBERTSON			4. DATE OF DEATH Month 4 Day 11 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1889
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sulphur Wells, Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James C. Robertson	
13b. MOTHER'S MAIDEN NAME Flora Arnett		14. NAME OF HUSBAND OR WIFE Edna (deceased)	
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. none	17. INFORMANT Carl R. Robertson Address Thayer, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia			INTERVAL BETWEEN ONSET AND DEATH 1 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Laryngeal Edema			1 hr.
DUE TO (c) Tuberculosis			1 Year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			19. WAS AUTOPSY PERFORMED? 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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 4-10-1959 - 5:40 PM to 4-11-1959 and last saw her/him alive on 4-11-1959 Death occurred at 10:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John W. Stueck M.D. (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 4-11-1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-15-59	23c. NAME OF CEMETERY OR CREMATORY Moten Cemetery	23d. LOCATION (City, town, or county) (State) Fulton Co., Arkansas.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. APR 15 '59	26. REGISTRAR'S SIGNATURE Coan Smith, M.D.

m 9B

1948

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 *Robert M. Murray*

Licensed Embalmer No. *3749*
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.