

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019568

STATE FILE NUMBER  
24149

FILED MAY 18 1959 Registration District No. Primary Registration District No. Registr. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                         |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b> |  | Length of stay in 1b.   | d. STREET ADDRESS (If outside, give location)<br><b>4139 Laclede Ave.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

3. NAME OF DECEASED (Type or print) First Middle Last  
**Parrie A. Robinson**

4. DATE OF DEATH Month Day Year  
**April 27, 1959**

|                         |                                  |   |  |  |   |                 |
|-------------------------|----------------------------------|---|--|--|---|-----------------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 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><b>Feb. 14, 1873</b> | 9. AGE (In years last birthday)<br><b>86</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS |
|-------------------------|----------------------------------|---|--|--|---|-----------------|

|   |   |   |   |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |
|---|---|---|---|

|  |   |  |
|--|---|--|
| 13a. FATHER'S NAME<br><b>Robert Dunn</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown Seals</b> | 14. NAME OF HUSBAND OR WIFE<br><b>George</b> |
|--|---|--|

|   |  |   |
|---|--|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT Address<br><b>Addie Earl, 4139 Laclede 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) **Fracture of Right Rib**

INTERVAL BETWEEN ONSET AND DEATH  
**903.6 44**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_  
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  NO

|  |  |
|--|--|
| 20a. ACCIDENT <input checked="" 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><b>suffered in fall to floor in hall</b> |
|--|--|

|  |  |   |  |
|--|--|---|--|
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year<br><b>4:25 p.m. 4-25-59</b> | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)<br><b>Hotel</b> | 20e. CITY, TOWN, OR LOCATION<br><b>St. Louis Mo</b> | 20f. COUNTY STATE<br><b>St. Louis Mo</b> |
|--|--|---|--|

|  |  |   |  |
|--|--|---|--|
| 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, etc.)<br><b>Hotel</b> | 20f. CITY, TOWN, OR LOCATION<br><b>St. Louis Mo</b> | 20g. COUNTY STATE<br><b>St. Louis Mo</b> |
|--|--|---|--|

21. I attended the deceased from \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

|   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| 22a. SIGNATURE (Deputy or title)<br><b>Joseph M. Zumbly</b> | 22b. ADDRESS<br><b>1300 Cedar</b> | 22c. DATE SIGNED<br><b>4/28/59</b> |
|---|-----------------------------------|------------------------------------|

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>4-30-59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Local</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Desloge, Mo.</b> |
|---|-----------------------------|--|--|

|   |   |  |
|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Albert H. Hoppe, 4700 Washington Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>APR 28 '59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Joseph M. Zumbly, M.D.</b> |
|---|---|--|

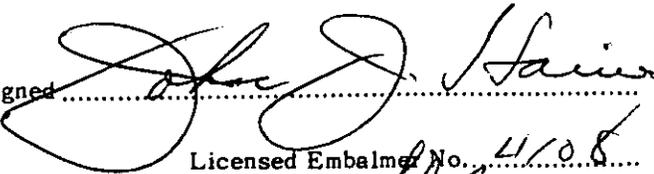
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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  .....  
Licensed Embalmer No. 4108 .....  
P. O. Address  .....

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.