

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8267
Do not use this space.

REC'D APR 12 1939

791
1003

Registered No. 2032

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City..... St. Louis (d) Street No. Homer Phillips Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 3 1/2 yrs. mo. ds. (f) How long in U. S., if of foreign birth? yrs. mo. ds.

2. PRINT FULL NAME 152 Rosetta Robinson
 (a) Residence, No. 1410 Biddle St. 25 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Separated

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22, 1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
40 8 4

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

FATHER
 13. NAME Arthur Williams
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

MOTHER
 15. MAIDEN NAME Lizzie Webb
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT (ADDRESS) Evelyn Hilliard
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE March 3 1939

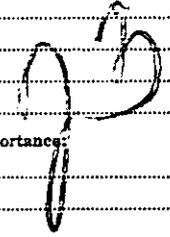
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J.W. Hughes
2620 Lewton Blvd

20. FILED MAR 2 1939 J.B. Bradley Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 26 1939

22. I HEREBY CERTIFY, That I attended deceased from June 9 1938 to Feb. 26 1939
 I last saw h. er. alive on Feb. 26 1939. Death is said to have occurred on the date stated above, at 5:55p.m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary tuberculosis
 Date of onset 6/9/38

Other contributory causes of importance:


Name of operation..... Date of.....
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) Mallou Fungal, M. D.
 (Address) 2601 N Whittier

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Leda Hughes*
Licensed Embalmer No. *2938*
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 this body is not embalmed, above space should be left blank.