

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community Unknown (Specify whether
year, months or days) 1.0 month

3. (a) PRINT FULL NAME MURIEL ROBINSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race col 6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MAY 12th 1939
(Month) (Day) (Year)

8. AGE: Years 10 Months 2 Days 2 If less than one day hr. min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Charles Robinson

13. Birthplace Little Rock ARK.
(City, town, or county) (State or foreign country)

14. Maiden name Etma Hollaway

15. Birthplace Little Rock ARK.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas Robinson

(b) Address 3022 MARKET

17. (a) removal (b) Date thereof 5-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LITTLE ROCK ARK.

18. (a) Signature of funeral director J. J. [unclear]

(b) Address 2769 Chestnut

19. (a) MAR 16 1940 (b) J. F. [unclear]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")

(d) Street No. 3022 Market
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11
year 1940 hour 3:40 minute _____ P. M.

21. I hereby certify that I attended the deceased from March 8, 1940, to March 11, 1940
that I last saw her alive on March 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 10 days

Due to Acute Nasopharyngitis
Cervical Adenitis, Rt

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature J. E. [unclear] (M. D. or other)

Address 2601 7th Street Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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

J Swatson

Licensed Embalmer No. *269A*

P. O. Address *2769 Chouteau*

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.