

No. 2
1-10-39
1-1492

SEP 25 1940

791

Registration District No. _____

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: **H G Phillins**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 days**
In this community **20 years**
years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Jerry Robinson** **157**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **499-01-2852**

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Sadie Robinson** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Dec 12 1872**
(Month) (Day) (Year)

8. AGE: Years **67** Months **7** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business **None**

MOTHER FATHER
12. Name **Alfred Robinson**
13. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Carolya unknown**
15. Birthplace **unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Sadie Robinson**
(b) Address **2023 Wash St**

17. (a) **Burial** (b) Date thereof **Aug 5 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood**

18. (a) Signature of funeral director **Mary Wade**
(b) Address **4202 Fruitway Ave**

19. (a) **AUG 1 1940** (b) **J. F. Oredock**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **0 Missouri** (b) County _____
(c) City or town **St Louis** **21**
(If outside city or town limit, write "RURAL")
(d) Street No. **2023 Wash**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30**
year **1940** hour **8:00** minute **P. M.**

21. I hereby certify that I attended the deceased from **July 18**, 19 **40** to **July 30**, 19 **40**,
that I last saw him alive on **July 30**, 19 **40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic Heart Disease** **10yrs**
Duration

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 **Allen C** (M. D. or other) _____
Address **2601 N Whittier** Date signed _____

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

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 *H. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2719 Route*

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.