

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

37454

Registration District No. 791

Primary Registration District No. 4000

Registrar's No. 9727

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 Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Life
 (Specify whether years, months or days) Life

3. (a) PRINT FULL NAME Robert Clement Cobbs

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

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased 10-10-40
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days 7 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 Clement Cobbs13. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Eddie Lou Sanders15. Birthplace Commerce Ga.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Ethel Mae Howard(b) Address 2601 N Whittier17. (a) Rural (Burial, cremation, or removal) (b) Date thereof 11-28-40
(Month) (Day) (Year)(c) Place: burial or cremation CITY CEMETERY18. (a) Signature of funeral director Mrs Hamilton(b) Address City Health Dept19. (a) NOV 27 1940 (Date received local registrar) (b) J. B. Black (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1213 JONES
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 17
year 1940 hour 3 minute 30 A. M.21. I hereby certify that I attended the deceased from 10-10-, 1940 to 10-17- 1940
that I last saw him alive on 10-17- 1940
and that death occurred on the date and hour stated above.Immediate cause of death Prematurity Duration _____

Due to _____

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) (e) Means of injury _____

23. Signature Dr. Peace (M. D. or other) _____Address 2601 N Whittier Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WHILE PRINTING—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I-119511

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.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.