

No. 2  
1-4-41  
-17-39  
X28390

**FILED AUG 28 1941 791**

1003

Registration District No. \_\_\_\_\_

Primary Registration District 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:  
**3916 Cora Ave.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

In this community..... **1**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **000**  
**17**

(c) City or town..... **St. Louis** **10 9**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3916 Cora Ave**  
(If rural, give location)

(e) Citizen of foreign country? **Cora** (Yes or No)  
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Jennie Robinson**

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **28**  
year **1941** hour **2** minute **55 P** M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Widowed**

6. (b) Name of husband or wife..... **Richard Robinson**

6. (c) Age of husband or wife if alive..... **1863** years

7. Birth date of deceased **April 15th 1863**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 1935** to **7/28 1941**

that I last saw her alive on **7/28 1941** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>78</b>	<b>3</b>	<b>13</b>	..... hr. .... min.

Immediate cause of death..... **apoplexy**

Due to **old age**

Due to **Chronic Myocarditis 6 yrs.**

Duration **4 days**

9. Birthplace **Washington D. C.**  
(City, town, or county) (State or foreign country)

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

10. Usual occupation..... **At Home**

11. Industry or business.....

Major findings:  
Of operations..... **936 938**

Of autopsy.....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name **Terrance Creamer**

13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Johanna Murphy**

15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ann Schultz**

(b) Address **3916 Cora Ave**

17. (a) **Burial** (b) Date thereof **7/31/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Calvary Cemetery**

18. (a) Signature of funeral director..... **Stroot - Carroll**

(b) Address..... **4600 Natural Bridge Ave**

19. (a) **Aug 29 1941** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

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?  
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature **Wilbur J. Hoke M. D.** (M. D. or other)  
Address **4278 Natural Bridge** Date signed **7/29/41**

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..... *L. H. Street* .....

Licensed Embalmer No. *#2265* .....

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, fact should be so stated above.**