

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5563

State File No. 2074

FILED MAR 13 1944

1005

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Saint Louis, Missouri

(b) City or town Saint Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Saint Mary's Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks (Specify whether)

In this community 36 years  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17/9

(c) City or town Saint Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4114 Enright Avenue  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ---

3. (a) PRINT FULL NAME ROBERT ROBINSON

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

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Carey Robinson 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Dec. 17 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

59	2	13	hr. min.
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9. Birthplace 9  
(City, town, or county) (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business ---

MOTHER FATHER

12. Name Edward Robinson

13. Birthplace Lexington, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Unknown

15. Birthplace Unavailable 9  
(City, town, or county) (State or foreign country)

16. (a) Informant William M. Robinson

(b) Address 4114 Enright Avenue

17. (a) Burial (b) Date thereof 3/2/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

19. (a) MAR 2 1944 (b) J. F. Brum  
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27th  
year 1944 hour 3: minute 55 A. M.

21. I hereby certify that I attended the deceased from Jan 17  
1944 to Feb 27, 1944  
that I last saw him alive on Feb 27, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis 6 months  
Due to 1 1/2 yr

Other conditions 1 yr  
(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. J. Aldrich (M. D. or other) 3/3/44  
Address 2605 A. Franklin Date signed ---

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

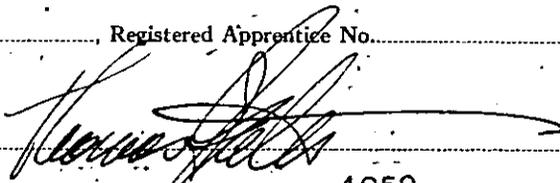
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

**Thomas J. Gates**

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....  


.....  
Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Avenue**

**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.**

Registration District No. 218

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Robert Robinia

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Dec 19 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) MAY 2 1944 (b) J. F. Brudick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

