. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1944

Registration District No. 377

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5063

38862

State File No.

Registrar's No. 2433

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community 1 year
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 8100 Elnora
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Robinson, Ardeluar

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 3

5. Color or race C

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Bennie Robinson

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 8 (Month) - 8 (Day) - 81 (Year)

8. AGE:

Years	Months	Days	If less than one day
63	3	18	hr. min.

9. Birthplace Austin, (City, town, or county) Texas 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name — Lowry
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Daughter: Patsy Burdine
(b) Address 501 Brentwood, Clayton

17. (a) (Burial, cremation, or removal) (b) Date thereof 12/1/44 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director R. M. Green
(b) Address 3517 Laclede Ave

19. (a) DEC 4 1944 (Date received local registrar) (b) E. G. McGavran M.D. (Registrar's signature) CMS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 26
year 44 hour 7 minute 03 P. M.

21. I hereby certify that I attended the deceased from 11-18, 1944 to 11-26, 1944
that I last saw her alive on 11-26-44, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to Hypertensive C-V Disease

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature H. Mayer M.D. 0 (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 [illegible]

Licensed Embalmer No. [illegible]173

P. O. Address 3[illegible]ale Ave

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.