V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32310

FILED OCT 25 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9006

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Pacific Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 21 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St Louis (If outside city or town limits, write "RURAL") 21 17
(d) Street No. 4410 a Evans ave (If rural, give location) 9
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Clifton Robinson
3. (b) If veteran, name war No.
3. (c) Social Security No.
4. Sex SM 2
5. Color or race C
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Evelyn Robinson
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased July (Month) 23 (Day) 1897 (Year)
8. AGE: Years 48 Months 2 Days 24 If less than one day hr. min.
9. Birthplace PETTUS (City, town, or county) ARK. (State or foreign country)
10. Usual occupation Waiter
11. Industry or business Dining Car
MOTHER FATHER
12. Name unavailable
13. Birthplace arkansas (City, town, or county) (State or foreign country)
14. Maiden name un.
15. Birthplace arkansas (City, town, or county) (State or foreign country)
16. (a) Informant Sarah Lawson
(b) Address 4357 aldine ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Pk Cem.
18. (a) Signature of funeral director Boyd Bros
(b) Address 3704 Finney ave
19. (a) OCT 18 1945 (Date received local registrar) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17 year 1945 hour 2 minute 00 A.M.
21. I hereby certify that I attended the deceased from October 16, 1945, to October 17, 1945; that I last saw him alive on October 17, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acedosis	Terminal
Due to Acute Gastro-enteritis	3 days
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature John Crowe (M. D. or other)
Address 1755 S. Grand St. Louis, Mo Date signed 10/17/45

(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 James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 3704 Finley

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.