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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 32313

FILED NOV 2 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9297

**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: 4403 Enright 1
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County

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

(d) Street No. 4403 Enright
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Pearl Robinson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 3

5. Color or race Negro

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

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

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased NOV. (Month) 27, (Day) 1897 (Year)

8. AGE: Years 47 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Pine Bluff (City, town, or county) Ark 1 (State or foreign country)

10. Usual occupation Beautician

11. Industry or business Beauty Salone

FATHER
12. Name Altheir
13. Birthplace Altheir (City, town, or county) Ark 1 (State or foreign country)

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

16. (a) Informant Eugene Robinson
(b) Address 3313 Franklin

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter Cem

18. (a) Signature of funeral director J. H. Harrison
(b) Address 2406 Lanton

19. (a) OCT 27 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct day 24 year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 22, 1945, to Oct 24, 1945, that I last saw her alive on Oct 23, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation and Anemia

Due to

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 R. Haskell (M. D. or other)

Address 4270 a St Finney Av Date signed 10/26/45

(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 Arthur L. Holliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard St

**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.**