. 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 NOV 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35789

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 10043

1. PLACE OF DEATH:

(a) County: St. Louis
(b) City or town: St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Louis Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 days (Specify whether years, months or days)
In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Louis
(c) City or town: St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 4593 Aldine Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Armelda Robinson
3. (b) If veteran, name war: No
3. (c) Social Security No. 499-28-5741
4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Henry Robinson
6. (c) Age of husband or wife if alive: 19 years
7. Birth date of deceased: May 27th 1926 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
19	5	20	hr. min.

9. Birthplace: St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: as above

FATHER
12. Name: Aloysius Chapman
13. Birthplace: Saint Louis (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Marguerite Craddock
15. Birthplace: Saint Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Saint Louis Maternity Hosp
(b) Address: 630 S. Kingshighway
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-24-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenwood Cemetery
18. (a) Signature of funeral director: Charles J. Gates
(b) Address: 4107 Finney Ave.
19. (a) NOV 20 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 17, 1945 year 1945 hour 6:05 AM minute M.
21. I hereby certify that I attended the deceased from November 8th, 1945 to November 17, 1945 that I last saw her alive on November 17th, 1945 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Hemorrhage
Due to: ruptured esophageal varix
Due to:
Other conditions (Include pregnancy within 3 months of death): Pregnancy (9 days post partum)
Major findings:
Of operations:
Of autopsy: Enlarged varices of esophagus + cardia of stomach

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: H. H. Masters (M. D. or other)
Address: 630 S. Kingshighway Date signed: 11-17-45

(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 Thomas J. Gtaes, Registered Apprentice No. _____, working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney 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.