

S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35790**
Registrar's No. **9909**

Registration District No. **318** Primary Registration District No. **1003**

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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 hours
(Specify whether
in this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1101 N Leonard
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Arthur Robinson
3. (b) If veteran, name war..... 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. **DATE OF DEATH:** Month Nov. day 13
year 1945 hour 10 minute 40 P. M.
21. I hereby certify that I attended the deceased from
Nov. 12, 1945 to Nov. 13, 1945;
that I last saw him alive on Nov. 13, 1945;
and that death occurred on the date and hour stated above.

4. Sex Male 2. Color or race W
5. Color or race W
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Lucie 6. (c) Age of husband or wife if
alive..... years
7. Birth date of deceased June 9th 1884
(Month) (Day) (Year)

Immediate cause of death.....
Far Advanced Pulmonary Tuberculosis Unk
Duration.....
Due to.....
Due to.....
Other conditions None
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
61 5 4 hr. min.

Major findings:
Of operations.....
Of autopsy Yes
PHYSICIAN
Underline the cause to which death should be charged statistically.

9. Birthplace Courtnth Miss
(City, town, or county) (State or foreign country)

10. Usual occupation nil

MOTHER FATHER
11. Industry or Business.....
12. Name John Robinson
13. Birthplace Courtnth Miss
(City, town, or county) (State or foreign country)
14. Maiden name Martha Ann
15. Birthplace unk Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Lucie Robinson
(b) Address 1101 N. Leonard Ave

17. (a) Burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle P. Son
(b) Address 3133 Bess Ave

19. (a) NOV 15 1945 (b) J. J. Redick
(Date received local registrar) (Registrar's signature)

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 W. B. Bennett (M. D. or other)
Address 260 N. Cahill Date signed 11/15/45

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:.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *J. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *27690 Route 1*

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.