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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22140

FILED JUN 20 1946

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 5037

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

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: MISSOURI PACIFIC HOSP. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5/14/46-5-31-46 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ARKANSAS (b) County 999

(c) City or town SMACKOVER 3 (If outside city or town limits, write "RURAL")

(d) Street No. N.R.D. (If rural, give location)

(e) Citizen of foreign country? — (~~Yes~~ or No) 2

If yes, name country —

3. (a) PRINT FULL NAME JAMES LESTER ROBINSON

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

4. Sex M 2

5. Color or race Cd

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 12 (Month) 6 (Day) 1886 (Year)

8. AGE: Years 59 Months 6 Days 25 If less than one day hr. min.

9. Birthplace SMACKOVER (City, town, or county) ARK 1 (State or foreign country)

10. Usual occupation FRG TRUCKER + PORTER

11. Industry or business MO PAC. R.R.

FATHER
12. Name UNKOWN
13. Birthplace 11 (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name 11
15. Birthplace 11 (City, town, or county) 9 (State or foreign country)

16. (a) Informant DR. DATESH
(b) Address 1755 S. GRAND

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6-2-46 (Month) (Day) (Year)

(c) Place: burial or cremation SMACKOVER ARK

18. (a) Signature of funeral director PEOPLES UND. CO
(b) Address 3100 FRANKLIN AVE.

19. (a) JUN 5 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 31 year 46 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....; that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Aneurysm

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 36

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 3

23. Signature Dr Alfred Perry D.C. (Dr. of Chiro.)

Address Cowners Office Date signed 6/1/96

(Licensed Embalmer's Statement on Reverse Side)

5037

AUG 21 1946

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 Jetie G. Pettus

Licensed Embalmer No. 4684

P. O. Address St. Louis, Mo.

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.