

S. No. 2  
1-12-45  
5-17-39  
X47070

FILED NOV 21 1946

5655

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 110 days  
(Specify whether years, months or days)

In this community 110 days

3. (a) PRINT FULL NAME Ruby Robinson

3. (b) If veteran, name war no

3. (c) SOCIAL SECURITY No. none

4. Sex Female 5. Color or race Colored

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased October 6 1909  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>1</u>	<u>5</u>	hr. _____ min.

9. Birthplace Edina Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Jim Robinson

13. Birthplace Steffenville Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Daisy Bryant

15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel McMichael, Record Clerk

(b) Address Mo. State San., Mount Vernon, Mo.

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 11/12/46  
(Month) (Day) (Year)

(c) Place: burial or cremation Edina Mo

18. (a) Signature of funeral director Geo. B. Carr

(b) Address Mo. State San., Mount Vernon, Mo.

19. (a) 11/12/46 (Date received local registrar)

(b) DR Philbrick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Knock

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11  
year 1946 hour 10 minute 40 p. M.

21. I hereby certify that I attended the deceased from July 25, 1946, to November 11, 1946  
that I last saw her alive on November 11, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration

about 1 yr.

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Bilateral pulm. Tuberculosis with giant size cavity in the right. Military spread

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 C. A. Grasher M.D.

Address Mo. State San., Mount Vernon, Mo. Date signed 11-12-46

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

RECEIVED

District Health Officer No. 6,

District File Number 1146-1152

Date Filed NOV 19 1946

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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.....  
*Geo. B. Orr*

Licensed Embalmer No. 946

P. O. Address.....  
*Mr. Vernon M. No.*

**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.