

No. 2  
12-45  
17-39  
X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3584  
Registrar's No. 270

FILED FEB 10 1947

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County Kath. Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr 7 mos 15 days  
(Specify whether  
In this community 11 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County AAO  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 17  
(d) Street No. 1640 Love Joy Lane  
(If rural, give location) 9  
(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME VELESTER HARRIS ROBINSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James Wesley Robinson 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased 6 12 1916  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Cotton Plant Arkansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesgirl

11. Industry or business

MOTHER FATHER

12. Name Columbus W. Harris

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

14. Maiden name Mattie York

15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Dement & Son

(b) Address 2620-31 Colo. Street

19. (a) 2-7-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3 year 1947 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from 6-19 1945 to 2-3- 1947  
that I last saw h. er alive on 2-3- 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 2 yrs. (?)

Due to Endo-bronchial tuberculosis

Due to \_\_\_\_\_  
Other conditions 13/5  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 D

23. Signature Bened Friedman (M. D. or other) MD  
Address Robert Koch Hospital Date signed 2-3-47

AUG 22 1950

OCT 3 1952

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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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard av

**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.