

No. 2  
-12-45  
5-17-39  
PI X47070

**FILED MAR 31 1947**  
**318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003** Registrar's No. **2793**

**1. PLACE OF DEATH:**

(a) County St. Louis, Missouri

(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:  
St. Louis City Hospital - ax E. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days) 25 1/2 hr.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 1115 E. WALTON  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Fred Robinson

3. (b) If veteran, name war World War II 3. (c) Social Security No. 492-03-5386

4. Sex M. (2) 5. Color or race Col

6. (a) ~~Single, widowed, married,~~ MARRIED

6. (b) Name of husband or wife WIFE 6. (c) Age of ~~husband~~ or wife if alive 32 years

7. Birth date of deceased June 14 1913  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 13th year 1947 hour 3:12 minute A M.

21. I hereby certify that I attended the deceased from 3/4/47 to 3/13/47 19\_\_\_\_; that I last saw him alive on 3/13/47 19\_\_\_\_; and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>33</u>	<u>8</u>	<u>29</u>	hr. min.

Immediate cause of death Respiratory failure Duration \_\_\_\_\_

Due to Meningitis - Streptococcus

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

9. Birthplace CRAWFORD MISS. (City, town, or county) (State or foreign country)

10. Usual occupation PULLMAN PORTER

Other conditions (Include pregnancy within 3 months of death) 81

**MOTHER FATHER**

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

12. Name DOUGLAS JOHNSON

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

14. Maiden name FANNIE STALLING

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

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

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mazie Robinson

(b) Address 1115 WALTON AVE

17. (a) BURIAL (burial, cremation, or removal) (b) Date thereof 3/17/47 (Month) (Day) (Year)

(c) Place: burial or cremation WASHINGTON PARK

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? \_\_\_\_\_

18. (a) Signature of funeral director F. A. GREENE

(b) Address 2915 FRANKLIN AVE.

19. (a) MAR 17 1947 (Date received local registrar) J. F. Bredeck (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Warren C. Lewis, M.D. (M.D. or other) Address 1515 Lafayette Date signed 3-13-47

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

APR 30 1947

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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 J. C. Green

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

**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.