

No. 2
-12-45
-17-39
X 47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11459

State File No. _____

FILED MAR 31 1947
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2815

1. PLACE OF DEATH:

(a) County None

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

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs
(Specify whether years, months or days)

In this community abt 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County None *ooo*

(c) City or town Saint Louis *1717*
(If outside city or town limits, write "RURAL")

(d) Street No. 4359 St. Ferdinand Avenue *9*
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ROBINSON, Roscoe

3. (b) If veteran, name war I.

3. (c) Social Security No. 489-09-3297

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12th
year 1947 hour 9: minute 40 p.M.

4. Sex Male U.S. Color or race Negro

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

6. (b) Name of husband or wife Lillie

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March 7th, 1896
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day _____hr. _____min.
<u>51</u>	<u>0</u>	<u>5</u>	

Immediate cause of death _____

Due to Bronch Pneumonia

9. Birthplace Nashville Tennessee
(City, town, or county) (State or foreign country)

Due to _____

Other conditions 107
(Include pregnancy within 3 months of death)

10. Usual occupation Moulder

11. Industry or business Scullins Steel Company

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

12. Name Unavailable

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

14. Maiden name Maggie Robinson

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

16. (a) Informant Lillie Robinson

(b) Address 4359 St. Ferdinand Ave.

17. (a) Burial (b) Date thereof 3-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Avenue

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

22. If death was due to external causes, fill in the following:

(c) 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? 3

While at work? _____ (Specify type of place)

(c) Means of injury Patriot E Taylor # 13-47

23. Signature Patriot E Taylor (M. D. or other) _____

Address 1300 Clark Avenue Date signed _____

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

STATEMENT BY LICENSED EMBALMER

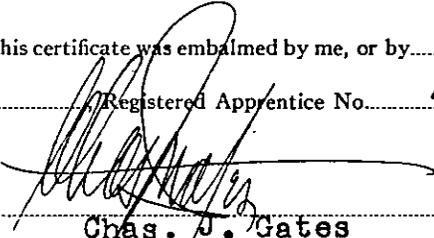
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

John K. Cunningham

working under my personal supervision.

Registered Apprentice No. **452**

Signed.....


Chas. J. Gates

Licensed Embalmer No. **1825**

P. O. Address **4107 Finney Ave.**

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.