

No. 2  
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17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15583

FILED APR 25 1947 318

State File No. \_\_\_\_\_

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

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

Registrar's No. 3963

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:  
4593 Kennerly Ave. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 6 years  
years, months or days

3. (a) PRINT FULL NAME JESSIE ROBINSON

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

4. Sex Female 5. Color Col. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Ben Robinson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug. 13 1891  
(Month) (Day) (Year)

8. AGE: Years 55 Months 8 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace O'Fallon Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Liberty Abbington

13. Birthplace O'Fallon Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Eldora Welch

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

16. (a) Informant Camille Moore

(b) Address 4593 Kennerly Ave.

17. (a) Removal-Motor (b) Date thereof 4/18/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O'Fallon Missouri

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

(b) Address 4107 Finney Ave.

19. (a) APR 16 1947 (b) J. F. Bredsch  
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4593 Kennerly Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13  
year 1947 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from January 21, 1947 to April 13, 1947  
that I last saw her alive on April 13, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myo-carditis (cardio-vascular) disease

Due to Hyper tension

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

Other conditions (Include pregnancy within 3 months of death) 93

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

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

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 James W. Smith (M. D. or other) \_\_\_\_\_

Address 901a N. Vandeventer Date signed 4/14/47

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Cunningham

Registered Apprentice No. 452

working under my personal supervision.

Signed.....

  
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.**