No. 2
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19624

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 1042

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town RICHMOND HTS MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST MARYS HOSP
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 MONTHS (Specify whether
In this community 3 MO
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS
(c) City or town RICHMOND HTS MO
(If outside city or town limits, write "RURAL")
(d) Street No. 1100 BELLEVUE AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME SISTER-MARY-INEZ {AMNA STELLA ROBINSON
3. (b) If veteran, name war —
3. (c) Social Security No. NONE
4. Sex F
5. Color or race W
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 NOV (Month) 30 (Day) 1896 (Year)

8. AGE: Years 50 Months 5 Days 19 If less than one day hr. min.

9. Birthplace CASTLEGROVE (City, town, or county) IOWA (State or foreign country)
10. Usual occupation SISTER IN RELIGION
11. Industry or business SISTERS OF ST MARY
FATHER
12. Name GEORGE ROBINSON
13. Birthplace BANCROFT (City, town, or county) NEBRASKA (State or foreign country)
MOTHER
14. Maiden name AGNES T BALLARD
15. Birthplace CASCADE (City, town, or county) IOWA (State or foreign country)
16. (a) Informant Rev Mother Irene
(b) Address 1100 Bellevue Ave
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAY 22-1947 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ OLD ST PETER + PAUL
18. (a) Signature of funeral director Watson Bockrage
(b) Address 6536 Clayton Rd
19. (a) 5-23-47 (Date received local registrar) (b) Cecil A J Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19th year 1947 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from Nov. 1st, 1946, to May 19, 1947 that I last saw her alive on May 19, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypernephroma of right Kidney with metastases to lungs, lymph glands ~~Due to~~ bones and brain.	6 Months
Due to 520	
Other conditions (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G O Brown (M. D. or other) MD
Address 1325 S. Grand Blvd. Date signed 5/28/47

(Licensed Embalmer's Statement on Reverse Side)

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. Allen Davis Jr.

Licensed Embalmer No. 4953

P. O. Address St Louis

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.