S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1947

Registration District No. 347

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3070

State File No. 33248

Registrar's No. 2039

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution 609 Halland 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 Life Time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Webester Groves 7
(If outside city or town limits, write "RURAL")

(d) Street No. 609 Halland ave 4
(If rural, give location) 0

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

If yes, name country .....

3. (a) PRINT FULL NAME LILLIAN ROBINSON

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Roy Robinson

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased March (Month) 9th (Day) 1889 (Year)

8. AGE:

Years	Months	Days	If less than one day
58	6	18	..... hr. ..... min.

9. Birthplace Webester Groves (City, town, or county) (State or foreign country) 0

10. Usual occupation Housework

11. Industry or business .....

FATHER
12. Name William Wright
13. Birthplace South Carolina (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name Jeanetta Gray
15. Birthplace Kansas City Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Roy Robinson
(b) Address 609 Halland ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director C. W. Roberts
(b) Address 1416 No. Taylor ave

19. (a) 10-2-47 (Date received local registrar) (b) Cecila J. Shaf MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27
year 1947 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from SEPT. 20, 1947, to SEPT 27, 1947; that I last saw her alive on SEPT 20, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	30 min.
Due to Hypertensive Cardiovascular Disease	9 months
Due to 93d	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN

Underline the cause of 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 (1)

23. Signature James B. Jones (M. D. ~~or other~~) M.D.

Address 337 W. Lockwood Webster Groves 19, Mo. Date signed Sept. 28 1947

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

APR 8 '48

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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address St. Louis 13, Mo.

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.