

No. 2  
5-43  
17-39  
X38671

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 13

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(c) Name of hospital or institution: South East Hospital  
(d) Length of stay: In hospital or institution 2 hours  
In this community all life  
years, months or days

3. (a) PRINT FULL NAME Infant "L" Robinson  
3. (b) If veteran, name war. No.  
3. (c) Social Security No.

4. Sex Female 5. Color or race Negro  
6. (a) Single, widowed, married, divorced,  divorced  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Jan 12 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
- - - 2 hr. 55 min.

9. Birthplace Cape Girardeau Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Inf

11. Industry or business

MOTHER FATHER  
12. Name George Robinson 1  
13. Birthplace Atlanta Ga 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Rosa Lee Simpson  
15. Birthplace Macon Ga 1  
(City, town, or county) (State or foreign country)

16. (a) Informant George Robinson  
(b) Address Parkville Mo  
17. (a) Burial (b) Date thereof 1-13-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Parkville Mo

18. (a) Signature of funeral director Della Funeral Home  
(b) Address Parkville Mo

19. (a) 1-14-48 (b) H. C. Senn  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County New Madrid  
(c) City or town Postageville Mo  
(d) Street No. 0  
(e) Citizen of foreign country? No  
If yes, name country

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January Day 12<sup>th</sup>  
Year 1948 Hour 12 minute 55 P.M.  
21. I hereby certify that I attended the deceased from 10 AM  
Jan 12 1948 to 12 55 pm 1948  
that I last saw her alive on Jan 12 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
INTRACRANIAL HEMORRHAGE  
Duration 3 hrs

Due to  
Due to Difficult Labor 2 days

Other conditions  
Major findings: Of operations 1600

Of autopsy INTRACRANIAL HEMORRHAGE  
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?  
(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 J. A. Kinder (M. D. or other) M.D.  
Address 826 1/2 S. Main Cape Girardeau Mo Date signed 1-12-48

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

Health Officer No. 4  
File Number 148-86  
Date Filed 1-19-48

**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.....

Not Embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed W. H. Estes.....

Licensed Embalmer No. 3568.....

P. O. Address Cape Girardeau.....

**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.**