

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

35522
 State File No. 9359

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place) 9 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Robinson		4. DATE OF DEATH (Month) (Day) (Year) Oct 28 1949	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 6-22-89
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME Georgia A. Goff	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME John D. Kelley	
17. ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Hypertensive Heart Disease	
18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		18. INTERVAL BETWEEN ONSET AND DEATH, Unk Unk	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 931	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? AA3X		22. I hereby certify that I attended the deceased from Oct 19, 1949 to October 28, 1949 that I last saw the deceased alive on October 28, 1949 , and that death occurred at 9:33 Pm. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) J. T. Hedrick M D		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 10-29-49		24a. BURIAL (CREMATION) REMOVAL (Specify) Burial	
24b. DATE 11-1-49		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cem. St. Louis Mo	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Manuel Und. Co.	
25. ADDRESS 4059 Finney		DATE REC'D BY LOCAL REG. OCT 31 1949	
REGISTRAR'S SIGNATURE J. O. Jasater		ADDRESS	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Aldine*

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.