

11/15/51

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

State File No. 35549
9010

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place) 11 years		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		e. STREET ADDRESS (If rural, give location) 826a N. 15th Street	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Goldie	b. (Middle)	c. (Last) Robinson	(Month) 10	(Day) 10	(Year) 51
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 7/16/1894	9. AGE (in years last birthday) 57	IF UNDER 1 YEAR Months 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Cap cutter		10b. KIND OF BUSINESS OR INDUSTRY Caradine Hat Co.	11. BIRTHPLACE (State or foreign country) Cairo, Illinois		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mable Robinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 498-09-1508	17. INFORMANT'S SIGNATURE OR NAME Hazel Davis, 817a N. 15th St.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Atypical pneumonia</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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? <i>H92X</i>

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at *2:45 P.* m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	23b. ADDRESS <i>1300 Clark</i>	23c. DATE SIGNED <i>10/13/51</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <i>10/15/51</i>	24c. NAME OF CEMETERY OR CREMATORY National Cemetery
24d. LOCATION (City, town, or county) (State) Jefferson Barracks, MO.	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	
DATE REC'D BY LOCAL REG. <i>OCT 13 1951</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	ADDRESS GATES FUNERAL HOME Charles J. Gates, 4107 Finney Ave.

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *James Sales*

Signed
Student Embalmer

Licensed Embalmer No. 4259

P. O. Address 4107 7th

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.