Health, Welfare Public Service

300 6
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042165
STATE FILE NUMBER

XC 8308026
SL 31391
FILED DEC 9 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11558

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N GRAND ST LOUIS MO — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VETS ADMIN HOSPITAL — Length of stay in Ib: 48 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5238 MINERVA — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOSEPH Middle E. Last ROBINSON

4. DATE OF DEATH: Month NOV Day 27 Year 1958

5. SEX: MALE 2

6. COLOR OR RACE: NEGRO

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 3/29/22

9. AGE (In years last birthday): 36 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POSTAL CLERK

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): MOUNDS, ILL.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: ORDELL ROBINSON

13b. MOTHER'S MAIDEN NAME: AMENTA KELLEY

14. NAME OF HUSBAND OR WIFE: OREDA B ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 491180716

17. INFORMANT Address: VA HOSP RECORDS 915 N GRAND ST LOUIS, MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HODGEKINS DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 3 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 201 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I VA attended the deceased from 10/9/58, to 11/27/58 and last saw him alive on 11/27/58
Death occurred at 2:05 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE V. A. Codiga (Degree or title) M.D.
V. A. Codiga
22b. ADDRESS: VAH, ST LOUIS, MISSOURI
22c. DATE SIGNED: 11/27/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12-2-1958
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Missouri

24. FUNERAL DIRECTOR: C. B. Pounce
ADDRESS: 1221 N. Grand
25. DATE RECD. BY LOCAL REG.: DEC 1 '58
26. REGISTRAR'S SIGNATURE: Earl Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....
Signature of Student Embalmer

Signed Clarence Graams

Licensed Embalmer No. 4755

P. O. Address 1221 N Gra

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.