

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Registration District No. **703** Primary Registration District No. _____

1. PLACE OF DEATH: **LUOS**

(a) County **St Louis**

(b) City or town **St Louis**

(c) Name of hospital or institution: **Homer G Phillips Hospital**

(d) Length of stay: **7 days**

In this community **Unknown**

8. (a) PRINT FULL NAME **Callie Robinson**

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John Robinson**

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

7. Birth date of deceased **Unavailable about 1888**

8. AGE: Years **About 51** Months _____ Days _____

If less than one day hr. _____ min. _____

9. Birthplace **Tunica Mississippi**

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Proctor**

13. Birthplace **Tunica Mississippi**

14. Maiden name **Sarah Unknown**

15. Birthplace **Tunica Mississippi**

16. (a) Informant's own signature **Callie Robinson**

(b) Address **4247 W. Market St.**

17. (a) **Burial** (b) Date thereof **12-16-39**

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Charles J. Gates**

(b) Address **4107 Finney Ave.**

19. (a) **DEC 16 1939** (b) **J. B. [Signature]**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **St Louis**

(d) Street No. **4247 West North Market St.**

(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **12th**

year **1939** hour **12** minute **52** P. M.

21. I hereby certify that I attended the deceased from **December 6**, 19**39**, to **December 12**, 19**39**;

that I last saw him alive on **December 12**, 19**39**;

and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|------------------------------------|----------|
| Bronchopneumonia | 4 das |
| Cerebral Hemorrhage | 4 das |
| prob involuntional psychosis | 3 mos |
| Due to _____ | |
| Due to _____ | |
| Other conditions _____ | |
| Major findings _____ | |
| Of autopsy Bronchopneumonia | |

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) _____

Means of injury **1**

28. Signature **Leon A. Smart** (M. D. or other) _____

Address **2601 N Whittier** Date signed _____

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.....

James A. Johnson

....., Registered Apprentice No.....

working under my personal supervision.

Signed *James A. Johnson*.....

Licensed Embalmer No..... **5522**.....

P. O. Address **4107 Finney Ave.**.....

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, above space should be left blank.