

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 31 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23391  
6553  
Registrar's No.

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: BARNES HOSPITAL  
(d) Length of stay: In hospital or institution 21 days  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo.  
(b) County St. Louis  
(c) City or town Webster Groves  
(d) Street No. 7 Allison  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Robert Redon

3. (b) If veteran, name war 3. (c) Social Security No. 495-128777

4. Sex male 5. Color or race negro  
6. (a) Single, widowed, married divorced  
6. (b) Name of husband or wife Leona Redon  
6. (c) Age of husband or wife if alive 49 years  
7. Birth date of deceased 3 17 1894

8. AGE: Years 49 Months 3 Days 29 If less than one day

9. Birthplace Jacksonville Ill-1

10. Usual occupation janitor

11. Industry or business  
12. Name Jerry Redon  
13. Birthplace Jacksonville Ill-1  
14. Maiden name Mary  
15. Birthplace Louisiana Mo

16. (a) Informant Leona Redon  
(b) Address 7 Allison

17. (a) Burial (b) Date thereof 7-22-43

18. (a) Signature of funeral director Jc Lewis  
(b) Address Webster Groves

19. (a) III 20 1943 (b) Registrar's signature J. Prudek

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1943 hour 10:58 minute P M.

21. I hereby certify that I attended the deceased from June 25 1943 to July 16 1943 that I last saw him alive on July 16 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Multiple myeloma metastases

Due to Due to Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Of autopsy Multiple myeloma metastases to skull, pelvis, femur, etc.

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 Melvin Goldman (M. D. or other) Address BARNES HOSPITAL Date signed

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

MOTHER FATHER

**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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed *J. Lewis*

Licensed Embalmer No. *2027*

P. O. Address *Webster Groves*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 6553

1. PLACE OF DEATH:

(a) County St Louis mo  
(b) City or town St Louis mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Robert Redon

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 49 Months 3 Days 29 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address Webster Groves, Mo

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) OCT 27 1943 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St Louis  
(c) City or town Webster Groves  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 Albee  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-23391