

FILED MAY 2 1944 318

Primary Registration District No. 1003

Registrar's No. 3853

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 1/2 Hrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3122 Marnice Place.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Lillian Ann Robinson

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: 3 (Month) 3 (Day) 44 (Year)

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

10 hr. 30 min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name E. L. Robinson

13. Birthplace Shannon Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Alberta Finney

15. Birthplace Nelton Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant Walter M. Sherard, R.N.
(b) Address 2601 N. Whittier Street

17. (a)..... (b) Date thereof APR 27 1944
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. J. Merschman
(b) Address City Health Dept

19. (a) APR 26 1944 (Date received local registrar) J. J. Merschman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 4
year 44 hour 8 minute 20 a.m.

21. I hereby certify that I attended the deceased from 3 - 3
19 44 to 3 - 4, 19 44
that I last saw her alive on 3 - 4, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to Unknown

Due to Unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 0

23. Signature W. J. Sunkle (M.D. or other).....
Address 2601 N. Whittier Street Signed 4-24-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

00
17
9

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.....

Licensed Embalmer No.....

P. O. Address.....

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.