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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 12 1945

State File No. 29345

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 8327

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

1. PLACE OF DEATH:

(a) County

(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: 221 Florida
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County
(c) City or town ST. LOUIS.
(If outside city or town limits, write "RURAL")

(d) Street No. 221 FLORIDA.
(If rural, give location)

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

3. (a) PRINT FULL NAME GEORGE A. ROBINSON.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W.

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife STELLA ROBINSON

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

7. Birth date of deceased Jan (Month) 5 (Day) (Year)

8. AGE: Years 68 Months 8 Days 20 If less than one day hr. min.

9. Birthplace ST. LOUIS. MO. (City, town, or county) (State or foreign country)

10. Usual occupation FOREMAN

11. Industry or business COTTON BELT.

FATHER
12. Name WILLIAM J. ROBINSON
13. Birthplace ENGLAND (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name JULIA ALOSKETT
15. Birthplace ENGLAND (City, town, or county) (State or foreign country)

16. (a) Informant Robert A. Robinson
(b) Address 221 Florida

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28 43 (Month) (Day) (Year)
(c) Place: burial or cremation St Peter & Paul

18. (a) Signature of funeral director Provost
(b) Address 3719 D. Farma

19. (a) SEP 26 1945 (Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 23 year 1945 hour 3 minute P. M.

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

	Duration
Immediate cause of death Chronic Coronary	
Due to Heart disease	
Due to Pneumonia	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed 9/26/45

(Licensed Embalmer's Statement on Reverse Side)

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 Earl E. Provost

Licensed Embalmer No. 1578

P. O. Address 3710 N. Grand

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.