

No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 28154
Registrar's No. 7639

FILED SEP 13 1948
318
Registration District No. _____

Primary Registration District No. _____

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

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 8 days
In this community 12 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Willie Robinson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 25, 1902
(Month) (Day) (Year)

8. AGE: Years 46 Months 1 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace Unk Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER
12. Name Martin Robinson
13. Birthplace Unk Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Georgia Raven
15. Birthplace Unk Fla
(City, town, or county) (State or foreign country)

16. (a) Informant S Jenkins, Med Dir's Office
(b) Address Homer G Phillips Hospital

17. (a) Anatomical Board (b) Date thereof 8-31-48
(Name, title, or office) (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service
(b) Address 4104 Manchester Ave.

19. (a) 8-31-48 (b) J. F. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Workingmen Hotel - 1421 Hogan
21 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 2
year 1948 hour 9 minute 30 P. M.
21. I hereby certify that I attended the deceased from July 25, 19 48 to August 2, 19 48
that I last saw him alive on August 2, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis Duration Unk

Due to _____
Due to _____
Other conditions 1/2
(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 J. Daniel (M. D. or other) _____
Address 2601 N Whittier Date signed 8-5-48

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.