V. S. No. 300
50M—10-47
Rev. 5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1949

Registration District No. 318

Primary Registration District No. 1003

State File No. 41785

Registrar's No. 10929

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:
St. Anthonys 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

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

(d) Street No. ~~St. Anthonys Hospital~~ 157 E Arlee ave
(If street give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Baby Robinson

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race single

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

6. (b) Name of husband or wife

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

7. Birth date of deceased December 18, 1948
(Month) (Day) (Year)

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

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

10. Usual occupation —

11. Industry or business —

FATHER
12. Name James Robinson
13. Birthplace Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adriana Delfose
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James Robinson
(b) Address 157 E. Arlee

17. (a) burial (b) Date thereof 12/18/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olive

18. (a) Signature of funeral director Fendler Und. Co.
(b) Address 7420 Michigan Ave.

19. (a) DEC 18 1948 (b) J. B. Lasater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18
year 48 hour 2 minute 9 M.

21. I hereby certify that I attended the deceased from 12-18, 1948, to 12-18, 1948
that I last saw he alive on 12-18-48, 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature ness	
Due to Placenta seperation	10 days
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Louis A. Crenlus (M. D. or other)
Address 752 Lemay Ferry Rd Date signed 12/18/48

(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.

Not Embalmed

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.