

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis Mo**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **St. Louis Childrens Hospital**  
(d) Length of stay: In hospital or institution **6 Weeks**  
In this community **4 Months**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis** **4225 W Maffitt Ave**  
(d) Street No. **4225 /w Maffitt Ave**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Arnold Cole Robnett**  
3. (b) If veteran, name war. **No**  
3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Col**  
6. (a) Single, widowed, married, divorced **U**  
6. (b) Name of husband or wife **None**  
6. (c) Age of husband or wife if alive **None**  
7. Birth date of deceased **Aug 15, 1948**

8. AGE: Years Months Days If less than one day  
**4 4**

9. Birthplace **St. Louis Mo**

10. Usual occupation **Mill**

11. Industry or business **None**  
12. Name **Eugene Robnett**  
13. Birthplace **Mo**  
14. Maiden name **Hettie Cole**  
15. Birthplace **Mo**

16. (a) Informant **Eugene Robnett**  
(b) Address **4225 W Maffitt Ave**

17. (a) **BURIAL** (b) Date thereof **12/22/48**  
(c) Place: burial or cremation **WASHINGTON PARK**

18. (a) Signature of funeral director **Walter J. Smith**  
(b) Address **4247 W Maffitt Ave**

19. (a) **DEC 21 1948** (b) Registrar's signature **J. B. Laster**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **12** day **19** year **48** hour **11** minute **30 P.M.**  
21. I hereby certify that I attended the deceased from **11-6-** 19 **48** to **12-19** 19 **48**  
that I last saw him alive on **12-19** 19 **48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Insufficiency**  
Due to **Congenital Heart Disease**  
Other conditions **157**  
Major findings: Of operations **None**  
Of autopsy **None**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **None**  
(b) Date of occurrence **None**  
(c) Where did injury occur? **None**  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **None**  
While at work? **None**  
23. Signature **Dr. L. Thurston** (M. D. or other) **None**  
Address **None** Date signed **None**

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

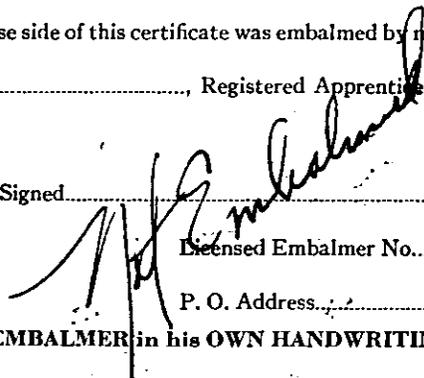
MOTHER FATHER

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**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.**