

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28480**
7731
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **100** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary Infirmary		f. STREET ADDRESS (If rural, give location) 3316 Rutger		D	
3. NAME OF DECEASED (Type or Print) a. (First) Odessa		b. (Middle)		c. (Last) Robinson	
5. SEX F		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Sept 27, 1902		9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 1 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Ark		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13a. FATHER'S NAME Robert Thornton		13b. MOTHER'S MAIDEN NAME Sarah Edward		14. NAME OF HUSBAND OR WIFE Ernest Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Bessie Clark	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) nephrosis		INTERVAL BETWEEN ONSET AND DEATH 2 mths	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) allergy			
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 183	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 371X	
22. I hereby certify that I attended the deceased from July 4, 1949 , to Sept 4, 1949 , that I last saw the deceased alive on Sept 4, 1949 , and that death occurred at 10:4 m., from the causes and on the date stated above.					
23a. SIGNATURE Walter C. Young		(Degree or title)		23b. ADDRESS 2837 Market	
23c. DATE SIGNED 9/6/49		24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Sept 6, 1949	
24c. NAME OF CEMETERY OR CREMATORY Marionna Ark		24d. LOCATION (City, town, or county) (State) Ark			
DATE RECEIVED BY LOCAL HEALTH DEPARTMENT SEP 6 1949		REGISTRAR'S SIGNATURE J. B. Lassater		25. FUNERAL DIRECTOR'S SIGNATURE F. C. Miller	
		ADDRESS 4214 Delmar			

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

of No. 18371X

APR 19 1961

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed F. C. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.