

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45523

State File No. 12297

FILED JAN 19 1954

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Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>0</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Homer G. Phillips</u>		e. STREET ADDRESS (If rural, give location) <u>2229 2229 Clark</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) c. (Last) <u>Robinson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 24 53</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-2-1899</u>
9. AGE (In years last birthday) <u>54</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>ST CHARLES MO.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>SAM ROBINSON</u>		13b. MOTHER'S MAIDEN NAME <u>NELLIE WYATT</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, m. no. or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>NELLIE JAMES</u> ADDRESS <u>9799 OLIVE</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Left Ventricular Failure</u> ANTECEDENT CAUSES DUE TO (b) _____ 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>4342</u>		22. I hereby certify that I attended the deceased from <u>12/18/1953</u> , to <u>12/24/1953</u> , that I last saw the deceased alive on <u>12/24/1953</u> , and that death occurred at <u>1:25 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>E. B. Williams, M.D.</u>		23b. ADDRESS <u>2601 N. Whittier</u>	
23c. DATE SIGNED <u>12/26/53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	
24b. DATE <u>12-30-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>DAKDALE</u>	
24d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>3103 Washington</u>	
DATE REC'D BY LOCAL REG. <u>DEC 29 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	

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

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.....
Signature of Student Embalmer

Signed *H. Claude Gordo*

Licensed Embalmer No. *34*

P. O. Address *45751*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.