

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6455**
Registrar's No. **1293**

FILED FEB 21 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri 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	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3962a Greer Avenue		d. STREET ADDRESS (If rural, give location) 10 3962a Greer Avenue	

3. NAME OF DECEASED (Type or Print) ARAH ROBINSON			4. DATE OF DEATH (Month) (Day) (Year) Feb 7, 1955			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 1, 1885	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (City and State or Foreign Country) Oxford, Mississippi/		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME David Davidson		13b. MOTHER'S MAIDEN NAME Rosie - Unknown		14. NAME OF HUSBAND OR WIFE James Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Roseanna Lewis 3962a Greer Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia		ANTECEDENT CAUSES None					
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 X		19b. MAJOR FINDINGS OF OPERATION X X X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) X		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) (Min.) X		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? X X	

22. I hereby certify that I attended the deceased from **2-5-** **1955**, to **2-8-** **1955**, that I last saw the deceased alive on **2-5-** **1955**, and that death occurred at **8:15pm.**, from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Blue Moore, M.D.		23b. ADDRESS 4501a Easton Ave. Cit		23c. DATE SIGNED 2-10-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/12/1955		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Gates 4107 Finney Ave.			

S.P. (Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4107 Finney Avenue

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.