

FILED JUN 20 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20356

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4738</b>		
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 town or township) <b>St Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St Louis, Mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1721 Division Street</b>				STREET ADDRESS (If rural, give location) <b>1721 Division St</b>				
3. NAME OF DECEASED (Type or Print) <b>Worine Robinson</b>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <b>5-24-55</b>		(Month)		(Day)		(Year)		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept 12th 1917</b>		
9. AGE (In years last birthday) <b>37</b>		if UNDER 1 YEAR Months <b>8</b> Days <b>12</b>		if UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Greenville Miss,</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13a. FATHER'S NAME <b>Irring Scott</b>		13b. MOTHER'S MAIDEN NAME <b>Agustine Walker</b>		
14. NAME OF HUSBAND OR WIFE <b>Herbert Robinson</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____		
17. INFORMANT'S SIGNATURE OR NAME <b>Herbert Robinson</b>				ADDRESS <b>1721 Division</b>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Status Asthmaticus</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  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.				INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>241X</b>				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred <b>11:37 A</b> m., from the causes and on the date stated above.								
23a. SIGNATURE <b>Patrick J. Taylor Carover</b>				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>5.31.55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>June 1st 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis, Mo</b>		
DATE REC'D BY LOCAL REG. <b>MAY 31 1955</b>				REGISTRAR'S SIGNATURE <b>J. Carl Smith Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. L. Beal Und Co.</b>		
				ADDRESS <input checked="" type="checkbox"/> <b>4303 Delmar</b>				

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*John K. Cumming*

Licensed Embalmer No. 44

P. O. Address 2405 M

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.