

STANDARD CERTIFICATE OF DEATH

FILED OCT 25 1957

Registration District No. 318 Primary Registration District No. 1003

STATE FILE NUMBER

Registrar's No.

38055
9682

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN East St Louis 1128	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 30 Saint Louis Maternity		d. STREET ADDRESS 32 5431 Nelson	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last Robinson		Month Day Year October 8 1957	
5. SEX Undetermined	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Missouri
13a. FATHER'S NAME John Robinson		13b. MOTHER'S MAIDEN NAME Jewel Mae Holmon	14. NAME OF HUSBAND OR WIFE --
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	17. INFORMANT Address Jewel Mae Robinson Above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Age of gestation in compatible with life			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 40 mins
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) 776x			19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from October 8 1957 to October 8 1957 and last saw her/him alive on October 8 1957 Death occurred at 1:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas K. Altschany M.D.		22b. ADDRESS St. Louis Maternity Hospital	
		22c. DATE SIGNED 10-9-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-31-57	
		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR ADDRESS Rowland Hker 4104 Manchester		25. DATE RECD. BY LOCAL REG. OCT 17 '57	
26. REGISTRAR'S SIGNATURE Paul Smith Mo mjs			

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

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**