

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027278

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7338

1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3121 N. Taylor</u>		d. STREET ADDRESS (If outside, give location) <u>3121 No. Taylor</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lessie</u> Middle _____ Last <u>Robinson</u>			4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1875</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Jackson South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Levi Chavous</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Craig</u>	
14. NAME OF HUSBAND OR WIFE <u>Raymond Robinson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   16. SOCIAL SECURITY NO. _____   17. INFORMANT Address <u>Camilla Brooks 3121 N. Taylor</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive cerebral-vascular disease</u>		<u>1 month</u>
	DUE TO (c) <u>embolus 443X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? 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 WORK <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 <u>July 13, 1961</u> to <u>Aug 5, 1961</u> and last saw her alive on <u>Aug 4, 1961</u> Death occurred at <u>2 05 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>D. H. Wood, M.D.</u>		22b. ADDRESS <u>474 SE 20th</u>		22c. DATE SIGNED <u>8/5/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-9-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dicksons</u>	23d. LOCATION (City, town, or county) <u>Webster Groves Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Cunningham &amp; Moore 2405 Marcus</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 7 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 INSTEAD OF

TO SYSTEMS

**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

Signature

*Arthur P. Hilliard*

Licensed Embalmer No. 4221

P. O. Address

3100 Easton

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.