

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027378

STATE FILE NUMBER

318

1003

6576

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JUL 26 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		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) <u>St Louis</u>		Length of stay in 1b <u>35 years</u>	c. CITY OR TOWN <u>St Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D O A City, #2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>915 N 15 St</u>
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Sterly</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>61</u>	
5. SEX <u>F</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>12/19/04</u>
9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>
13a. FATHER'S NAME <u>John Robinson</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Speaks</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Jocie Robinson</u> Address <u>NY, NY</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 Apoplexy, right lateral ventricle.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>334X</u> DUE TO (c)			INTERNAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year			
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 _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Johnson</u> (Degree or title) <u>Deputy Coroner</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>7/14/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7.17.61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dixon</u>	23d. LOCATION (City, town or county) (State) <u>Webster Grove MO</u>
24. FUNERAL DIRECTOR <u>A. L. Burke</u> ADDRESS <u>3901 Ashland</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 14 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

**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 Leroy W. Pannistie

Licensed Embalmer No. 4523

P. O. Address 4251 Wash

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.