

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

MISSOURI OF PUBLIC HEALTH AND WELFARE

-62-020911
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5194**

FILED MAY 31 1962

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|--|--|-------|--|------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b D O A | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital # 1 | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 2431 Division Apt. 611 | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Clarence Robinson | | | | | | First | | Middle | | Last | | 4. DATE OF DEATH May 21, 1962 | | | | | |
| 5. SEX Male | | 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 Jul 19, 1910 | | 9. AGE (last birthday) 51 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HR Days | | Hours | | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | | | 10b. KIND OF BUSINESS OR INDUSTRY Material | | | | 11. BIRTHPLACE (City and state or country) St. Charles Missouri | | | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | | |
| 13a. FATHER'S NAME Otto Robinson | | | | 13b. MOTHER'S MAIDEN NAME Mary Mozee | | | | 14. NAME OF HUSBAND OR WIFE None | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, to unknown) (If yes, state year or dates of service) | | | | 16. SOCIAL SECURITY NO. [REDACTED] | | | | 17. INFORMANT Margaret Jones 6139 Gambleton Place | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of stomach | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ | | | | | | | | | | | | | | | | | |
| DUE TO (c) _____ | | | | | | | | | | | | 151x | | | | | |
| 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 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 _____ 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 _____ 12:35 P. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Paul Johnson | | | | | | 22b. ADDRESS 1300 Clark | | | | | | 22c. DATE SIGNED 5/22/62 | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Removal | | | | 23b. DATE 25 May 1962 | | 23c. NAME OF CEMETERY OR CREMATORY National Barracks Cem. | | | | 23d. LOCATION (City, town, or county) St. Louis County Mo. | | | | | | | |
| 24. FUNERAL DIRECTOR E. B. Koonce 1221 North Grand Blvd. | | | | | | 25. DATE RECD. BY LOCAL REG. MAY 22 1962 | | 26. REGISTRAR'S SIGNATURE Earl Smith. M.D. | | | | | | | | | |

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

Melvin Blackburn

Licensed Embalmer No. 3962

P. O. Address 1721 N. Grand Ave

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.