

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025108

STATE FILE NUMBER

318  
 1003  
 Registrar's District No. \_\_\_\_\_ Registrar's No. **6590**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

9/27/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Female

SHOULD READ

Male

BY AFFIDAVIT OF Informant

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN<br><b>St. Louis</b>   |   | Length of stay in 1b  | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Homer G. Phillips</b>   |   | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>4325A Garfield</b><br>Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Robinson</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>6 28 62</b>  |   |
| 5. SEX<br><b>Fem. Male</b>  | 6. COLOR OR RACE<br><b>Negro</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-22-62</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br>IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.<br><b>5</b>  |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Missouri</b>  |   | 12. CITIZEN OF WHAT COUNTRY   |   |
| 13a. FATHER'S NAME  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Joyce Anita Robinson</b>  | 14. NAME OF HUSBAND OR WIFE   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Address<br><b>Mrs. Mary D. Jett, R.R.L., 2601 N. Whittier</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br>DUE TO (b) _____<br>DUE TO (c) <b>776X</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>6-22-62</b> to <b>6-28-62</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>6-28-62</b><br>Death occurred at <b>2:30</b> <b>A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>Homer E. Phillips - M.D.</i>   |   | 22b. ADDRESS<br><b>2601 N. Whittier</b>   | 22c. DATE SIGNED<br><b>6-29-62</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>JUL 31 1962</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>   | 23d. LOCATION (City, town, or county) (State)   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Rowland Mortuary Svc. 4104-06 Manchester</b>   |   | 25. DATE REC'D. BY LOCAL REG.<br><b>JUL 5 1962</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Roald Smith, M.D.</i>   |

**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.