

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009290

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2400**
FILED MAR 14 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in lb 1 mth.	c. CITY OR TOWN Springfield
c. FULL NAME OF (If NOT in hospital, give HOSPITAL OR INSTITUTION) BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2205 Whittier
3. NAME OF DECEASED (Type or print) First Ida Middle NMN Last Robinson		4. DATE OF DEATH Month March Day 2 Year 1963	
5. SEX Female	6. COLOR OR RACE Cauc.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (last birthday) about 70		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) New York, N.Y.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Charles Lamberg	
13b. MOTHER'S MAIDEN NAME Sarah Title		14. NAME OF HUSBAND OR WIFE Sam	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sam Robinson 2205 Whittier		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) Glioblastoma of Brain			INTERVAL BETWEEN ONSET AND DEATH 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 193.0			
DUE TO (c)			
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 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 January 29, 1963 to March 2, 1963 and last saw her/him alive on March 2, 1963 Death occurred at 6:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F.R. Bradley, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/3/63
23a. BURIAL, CREMATION, REMOVAL (Specify) em.	23b. DATE 3/3/1963	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge	23d. LOCATION (City, town, or county) (State) Springfield, Illinois
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		25. DATE RECD. BY LOCAL REG. march 3, 1963	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.

6801 (1) JAN 1961

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 *James J. Judwig*

Licensed Embalmer No. 4229

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.**