

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-028609**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 4011

FILED AUG 6 1963

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>17 Yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. General Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1629 Norton</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>		
First Middle Last <u>WILLIE JAMES ROBINSON</u>			Month Day Year <u>July 13, 1963</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1/22/22</u>	<b>9. AGE (last birthday)</b> <u>41 Yrs.</u>	<b>IF UNDER 1 YEAR</b> Months Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Parrie Point, Miss.</u>	
<b>10c. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		<b>13a. FATHER'S NAME</b> <u>Charlie Robinson</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Hester Wallace</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Rosie B. Rose 317 1/2 E. 19th St</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line)		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u>		
DUE TO (b) <u>Myocardial Insufficiency.</u>		
DUE TO (c) <u>Coronary Artery Disease.</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 type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.		
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Tillman M.D. Deputy Coroner</u>	<b>22b. ADDRESS</b> <u>1618 Lydia Ave.</u>	<b>22c. DATE SIGNED</b> <u>7/15/63</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify).</b> <u>Removal</u>	<b>23b. DATE</b> <u>7/18/63</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Local Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Macon, Mississippi</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Mrs. Meek's Mortuary K. C. Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-16-63</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Ruth Long</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59  
 1  
 2 3 238  
 3  
 4 2  
 5 3  
 6  
 7 1  
 8 1  
 9 420.1  
 10  
 11  
 12 92.3  
 13  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 SHOULD READ  
 ITEM NO.

DATE AMENDED  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 Tillman

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Willard B. Perkins*

Licensed Embalmer No. 5013

P. O. Address A. C. M. O.

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.