

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034047

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9023** STATE FILE NUMBER

FILED SEP 12 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY		c. CITY OR TOWN		Inside Limits				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>3655 Vista</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Robinson</b>			4. DATE OF DEATH Month <b>September</b> Day <b>5,</b> Year <b>1963</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1872</b>	9. AGE (last birthday) <b>91</b>	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) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Osage County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Isaac Coffelt</b>				13b. MOTHER'S MAIDEN NAME <b>Carolina Knatzner</b>				14. NAME OF HUSBAND OR WIFE <b>William Robinson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No.</b> (If yes, give war or dates)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Reuel Gaume, 3655 Vista, Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage Rt</b>										INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>			
DUE TO (b) <b>Arteriosclerotic Vascular disease Chr</b>													
DUE TO (c) <b>331x</b>													
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 Month, Day, Year a.m. p.m.		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.) <b>Aug</b>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <b>Sept 10 1963</b> to <b>Sept 5 1963</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>Sept 5 1963</b> Death occurred at <b>12:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i> (Degree or title)						22b. ADDRESS <b>Webster Groves Mo.</b>			22c. DATE SIGNED <b>9/6/63</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-9-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mint Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Chamois, Mo.</b>		(State)					
24. FUNERAL DIRECTOR <b>Morton Funeral Home, Linn, Mo.</b> ADDRESS						25. DATE RECD. BY LOCAL REG. <b>SEP 7 1963</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

SEP 18 1963

**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

*Harvey Kable*

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

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.