

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**863-042411**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3289 STATE FILE NUMBER

**FILED OCT 30 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

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>PULASKI</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS MISSOURI</b>		Length of stay in 1b <b>554 DAYS</b>		c. CITY OR TOWN <b>MOUND CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>528 PEARL STREET</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BURA ROBINSON</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 26, 1963</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-92</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL LABOR</b>		11. BIRTHPLACE (City and state or country) <b>HARRISBURG, ARKANSAS</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>GEORGE ROBINSON</b>		13b. MOTHER'S MAIDEN NAME <b>JOSIE ROBINSON</b>	
14. NAME OF HUSBAND OR WIFE <b>CHERRY ROBINSON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>YES WW-1</b>			
16. SOCIAL SECURITY NO. <b>MM-1</b>		17. INFORMANT Address <b>CHERRY ROBINSON (WIFE) 528 PEARL STREET MOUND CITY, ILLINOIS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE BRONCHOPNEUMONIA</b>					INTERVAL BETWEEN ONSET AND DEATH <b>APPROX 1 WK</b>
DUE TO (b) <b>UNKNOWN BACTERIA</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>LYMPHOMA (TYPE TO BE DETERMINED) - ARTERIOSCLEROSIS GENERALIZED</b>					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 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 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>4-10-62</b> to <b>10-26-63</b>		<del>XXXXXXXXXXXX</del>			
Death occurred at <b>3:05 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) <i>Charles E. Gauthier</i>		22b. ADDRESS <b>GAUTHIER, M.D. VET ADM HOSP, JEFF BRKS, 25, MO</b>		22c. DATE SIGNED <b>10-27-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>REMOVAL</b>	<b>10-29-63</b>	<b>National Cemetary</b>		<b>Mounds City Ill</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Alstat Funeral Home Mounds City Ill.</b>		RECORDED BY LOCAL REG. <b>10-27-63</b>		26. REGISTRAR'S SIGNATURE <i>John B. Murphy</i>	

USE BLACK INK OR TYPEWRITER RIBBON

OCT 31 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 James J. Crisson

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

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.