

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH & Final Report by aff. of Physician

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 13074

STATE FILE NUMBER 0051050

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 16 1964

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		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 <b>St. Louis</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>Homer G. Phillips</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>1419 Burd Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <b>Arah</b> Middle Last <b>Robinson</b>			4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>63</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</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>5/13/1892</b>		9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>facker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>Athen, Texas</b>				12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>							
13a. FATHER'S NAME <b>Harrison Griffin</b>				13b. MOTHER'S MAIDEN NAME <b>Sarah</b>				14. NAME OF HUSBAND OR WIFE <b>Deceased</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Sadie Robinson 1419 Burd</b>				Address							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia</b> DUE TO (b) <del>Old Head Trauma</del> <b>Arteriosclerosis</b> DUE TO (c) <b>332X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</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 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 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE									
21. I attended the deceased from <b>12-27-63</b> to <b>12-28-63</b> and last saw him live on <b>12-28-63</b> Death occurred at <b>1:35 P</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>2601 N. Whittier St.</b>			22c. DATE SIGNED <b>12-30-63</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Dec 27, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>													
24. FUNERAL DIRECTOR <b>E.B. Kerne</b> ADDRESS <b>221 N. Grand Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 31 1963</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>													

VS 300 Rev. 4/59  
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DATE AMENDED **1-8-64**  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF **as record**  
ITEM NO. **18b** **Arteriosclerosis**  
**23c** **Washington Park Cemetery**  
BY AFFIDAVIT OF Physician & Undertaker DOCUMENT

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 Oliver E Crumble

Licensed Embalmer No. 5185

P. O. Address 1221 N Grand Ave

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.