

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046792

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11551**

STATE FILE NUMBER

AMENDED

FILED DEC 18 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
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. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
St. Louis, Missouri		St. Louis, Missouri		2 Weeks	Illinois		St. Clair		East St. Louis		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)				209 North 9th Street			
St. Mary's Infirmary				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year		
FLOYD S. ROBINSON			FLOYD	S.	ROBINSON	December 10, 1961		December	10	1961		
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		
Male	Negro			4/9/03		58		Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY					
Laborer			Swift & Company		St. Louis, Missouri		U. S. A.					
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE						
FLOYD ROBINSON, SR.			MELLIBUE SUTHERLAND			MARTHA ROBINSON						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					17. INFORMANT Address							
No					Martha Robinson, 209 North 9th Street, E. St. Louis							
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Descending Colon</i>										INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										153.2		
DUE TO (b)												
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 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 e.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 <u>11/27/61</u> to <u>12/10/61</u> and last saw ^{her} him alive on <u>12/10/61</u>		Death occurred at <u>6:12</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <i>John W. Jackson MD</i> (Degree or title)					22b. ADDRESS <i>1509 1/2 Bond East St. Louis, Ill</i>			22c. DATE SIGNED <i>DEC 12 1961</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)					
Burial		12/16/61		Sunset Gardens of Memory			Stookey Township, Illinois					
24. FUNERAL DIRECTOR <i>Marion Office</i> ADDRESS <i>2114 Missouri Avenue East St. Louis, Illinois</i>				25. DATE RECD. BY LOCAL REG. <i>DEC 12 1961</i>		26. REGISTRAR'S SIGNATURE <i>Boad Smith M.D.</i>						

STATE OF MISSOURI

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

Frank Prokopff

Licensed Embalmer No. 4356

P. O. Address St. Louis,

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.