

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025111

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **647E** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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8/20-7

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>ILLINOIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>East St. Louis</b>	
Length of stay in lb <b>5 Days</b>		Inside Limits <b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Inf.</b>		d. STREET ADDRESS (If outside, give location) <b>1418 So. 11th Street</b>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN ROBINSON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1962</b>	
5. SEX <b>Female</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>8/3/25</b>
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>None</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>
13a. FATHER'S NAME <b>WILLIE CRITE</b>		14. NAME OF HUSBAND OR WIFE <b>JAMES ROBINSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>James Robinson, 1418 So. 11th St., East St. Louis, Ill.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Hypertensive Vascular Disease</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 <b>7:30</b> Month, Day, Year <b>6-29-62</b>		20f. CITY, TOWN, OR LOCATION <b>East St. Louis</b> COUNTY <b>St. Clair</b> STATE <b>Ill.</b>	
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.)	
21. I attended the deceased from <b>6-27-62</b> to <b>6-29-62</b> and last saw her alive on <b>6-29-62</b> . Death occurred at <b>7:30</b> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M.E. Smith, M.D.</b> (Degree or title)		22b. ADDRESS <b>2715 Union St. East St. Louis, Mo</b>	
22c. DATE SIGNED <b>6-29-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/4/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens of Memory</b>	
23d. LOCATION (City, town, or county) <b>St. Louis, Ill.</b>		23e. LOCATION (State) <b>Ill.</b>	
24. FUNERAL DIRECTOR <b>Merrill Office</b> ADDRESS <b>2114 Missouri Ave. East St. Louis, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 30 1962</b>	
26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>			

2/18/23

**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 Marion O. Offin

Licensed Embalmer No. 5177

P. O. Address E. St. Louis, 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.