

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025112

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6218**

**FILED JUL 2 1962**

VS 300  
Rev. 4/59

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in lb <b>20 days</b>		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 (If outside, give location) <b>4346 Cote Brillante</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle Last <b>Robinson</b>			4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>62</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>12-12-1885</b>		9. AGE (last birthday) <b>76</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>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>			
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13a. FATHER'S NAME <b>Frank Rodgers</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Glenn</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 year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hilliard Robison</b>		Address <b>4638 Bessie</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Possible Pulmonary Embolus</b>										Undet.			
DUE TO (b) <b>Above-the-knee amputation, right</b>													
DUE TO (c) <b>Arteriosclerotic gangrene, right foot</b>										Undet.			
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.) <b>4501</b>							
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>5-30-62</b> to <b>6-19-62</b> and last saw her <b>xx</b> alive on <b>6-19-62</b>				Death occurred at <b>8:55</b> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>D.O. Richard MD</b>						22b. ADDRESS <b>2601 N. Whittier Avenue</b>			22c. DATE SIGNED <b>6-19-62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-25-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County</b>		Mo.					
24. FUNERAL DIRECTOR <b>B.S. Farrow</b>				ADDRESS <b>222 N. Grand</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 22 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>					

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

*Robert T. Taylor MD*  
*June 6-19-62*  
*Coroner*

77

**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 Alfred E. Quimble

Licensed Embalmer No. 5185

P. O. Address 1221 N. Grand

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.