

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029099

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6985**

FILED JUL 31 1962

VS 300
Rev. 4/59

1
2 20 69
3
4 2
5 9
6
7 1
8 2
9
10
11
12 77.3
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS | | c. CITY OR TOWN ST LOUIS | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER PH. H.S. | | d. STREET ADDRESS (If outside, give location) 5348 R. D. 9E | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First BENJAMIN Middle ROBINSON Last | | | 4. DATE OF DEATH Month July Day 10 Year 1962 |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-2-'99 |
| 9. AGE (last birthday) 63 | | IF UNDER 1 YEAR Months 1 Days 10 | IF UNDER 24 HR Hours 18 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) EUDORA ARK |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME E.D. ROBINSON | |
| 13b. MOTHER'S MAIDEN NAME LAURA ROUNDREE | | 14. NAME OF HUSBAND OR WIFE W. DOWER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT ROSIE GRAHAM | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Arteriosclerosis DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 7:15 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Paul Simon Deputy Coroner | | 22b. ADDRESS 1300 Clark | |
| 22c. DATE SIGNED 7/12/62 | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) REMOVAL 7-13-62 | | 23b. DATE MC GHEE | |
| 23c. NAME OF CEMETERY OR CREMATORY ARKANSAS | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR RELIABLE 1389 UNION | | 25. DATE RECD. BY LOCAL REG. JUL 12 1962 | |
| 26. REGISTRAR'S SIGNATURE Keon Smith MO | | | |

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 Clarence Croson

Licensed Embalmer No. 4755

P. O. Address 1389 Union

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.