

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1927

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

St. Louis

(No. *Alatian Bros Hospital*)

File No.....

Registered No.....

4026

St.....

Ward.....

2. FULL NAME

George W Webster

(a) Residence. No.....

4003 1/2 Old Ave

St.....

17

Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Annie J Webster

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 4-1865

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. ____ min.

61

9

23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Washington D. C.

PARENTS

10. NAME OF FATHER

Geo Webster

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT

(Address)

Mr Annie B Webster

4003 1/2 Old Ave

15.

FILED

APR 25 1927

19.....

May 6 Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April 27, 1927

17.

I HEREBY CERTIFY That I attended deceased from *Feb 1, 1926*, to *April 27, 1927*, that I last saw him alive on *April 26, 1927*, and that death occurred, on the date stated above, at *1 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, Lobar

83

3 1/2

100

(duration) - yrs. - mos. *6* da.

CONTRIBUTORY (SECONDARY)

General Paralysis of the Insane

(duration) - yrs. - mos. - da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

H. H. Huestenberg, M. D.

4/28, 1927 (Address) 325 Frisco Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Oak Grove

Apr 29 1927

20. UNDERTAKER

ADDRESS

Clement and Leo S Grand Blvd

2787

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No. *791* File No.
Township..... Primary Registration District No. *1003* Registered No. *4026*
City..... No. St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>M</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>M</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 27 1927*
17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar pneumonia
General paralysis
Given over phone by Dr. H. Winterberg

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: *Div. of V. S. 2-9-27*
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15. <i>Mar 6 Starceff</i>	20. UNDERTAKER	19
FILED		ADDRESS

SUPPLEMENTARY 76

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-11-68