

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

13476

FILED APR 20 1944

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3428

1. PLACE OF DEATH:

(a) County St. Louis Missouri  
 (b) City or town St. Louis Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 14 days  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Henry Webb

3. (b) If veteran, name war

No

3. (c) Social Security No.

4. Sex Male  White  
 5. Color or race  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Mary Webb  
 6. (c) Age of husband or wife if alive 64 years  
 7. Birth date of deceased December 24, 1880  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 3 12 hr. min.

9. Birthplace Dont Know USA  
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired WPA

11. Industry or business

MOTHER FATHER { 12. Name Don't Know  
 13. Birthplace Don't Know 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Don't Know  
 15. Birthplace Don't Know 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Webb  
 (b) Address 224 Sidney St.

17. (a) Burial (b) Date thereof April 13, 44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Weick Bros.  
 (b) Address 2201 S Grand St.

19. (a) APR 13 1944 (b) J. F. Bredes  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis 1723  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 224 Sidney St. 9  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th  
 year 1944 hour 10:13 minute P. M.

21. I hereby certify that I attended the deceased from March 24th  
 19 44, to April 6th, 19 44  
 that I last saw him alive on April 6th, 19 44  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-meningitis post operative  
 Due to not due to meningitis  
 Due to gonococcus  
 Other conditions (Include pregnancy within 3 months of death)

Duration 4 da.

Major findings: Posterior root section, cerebral meningitis  
 Of operations  
 Of autopsy

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify)  
 (b) Date of occurrence  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? D. J. Verda (Specify type of place) (a) Means of injury  
 23. Signature 1515 Lafayette (M, D or other) 4/13/44  
 Address Date signed

**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.....

*Not Embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Henry A. Stewart*

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette St.

**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 this body is not embalmed, fact should be so stated above.**