

S. No. 300
DM-10-47
v. 5-17-39
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14761

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 7 1948

Registration District No. **318**

Primary Registration District No. **1000**

Registrar's No. **4072**

1. PLACE OF DEATH:
(a) County **St. Louis Mo.**
(b) City or town **St. Louis Mo.**
(c) Name of hospital or institution: **3833 Olive St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or (days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3833 Olive 9**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charnee Webb**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex **Male** 5. Color **Black** 6. (b) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **25**
year **1948** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. Age at death: Years **34** Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace **Missouri** (City, town, or county) **Lee 29** (State or foreign country)
10. Usual occupation **cutting hair**
11. Industry or business **hair cut**
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

Immediate cause of death _____
Due to **Coronary Occlusion**
Due to **Coronary Sclerosis**
Other conditions **Fr. M.I.**
(Include pregnancy within 3 months of death)

MOTHER FATHER
16. (a) Informant **Thos. F. Caldwell**
(b) Address **1300 Olive St.**
17. (a) **Anatomical Board** (b) Date thereof **APR 30 1948**
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation **Anatomical Board**
18. (a) Signature of funeral director **Rowland Mortuary Service**
(b) Address **4104 Manchester Ave.**
19. (a) **APR 30 1948** (b) **J. F. Brudack**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____
Of autopsy **PH**
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 _____ (Specify type of place)
Means of injury **3**
23. Signature **Chas. Perry** (M. D. or other) _____
Date signed **4/5/48**

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed Ralph W Henson

Licensed Embalmer No. 3791

P. O. Address St. Louis, Mo

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.