

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10726

State File No. 1928
Registrar's No.

No. 300
10.48

FILED MAR 24 1952

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 1928		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY City Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri			c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069					
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 6 3353^a CLARA						
3. NAME OF DECEASED (Type or Print) a. (First) BENJAMIN			b. (Middle) _____		c. (Last) WASHBURN		4. DATE OF DEATH (Month) (Day) (Year) FEB. 27, 1952			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Oct-18-1889		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) De Soto		12. CITIZEN OF WHAT COUNTRY? 0			
13a. FATHER'S NAME William Washburn			13b. MOTHER'S MAIDEN NAME Anna Bounds			14. NAME OF HUSBAND OR WIFE Rose Washburn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Rachel Cantillon						ADDRESS 2116 No. 1st
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac failure - intractable ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? 4200						
22. I hereby certify that I attended the deceased from 2-21-52 , 19____, to 2-27-52 , 19____, that I last saw the deceased alive on 2-27-52 , 19____, and that death occurred at 10:15 P.m. , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) J. Smith M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 2-28-52				
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 2-3-52	24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) De Soto Mo					
DATE REC'D BY LOCAL REG. FEB 28 1952		REGISTRAR'S SIGNATURE Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin			ADDRESS 2301 Lafayette		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

H. G. Farris

Licensed Embalmer No. *3384*

P. O. Address *2301 Lafayette*

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.