

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>2/15/55</u>	c. CITY OR TOWN <u>St. Louis</u>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4159 Taft Ave.</u>			STREET ADDRESS (If rural, give location) <u>4159 Taft Ave.</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Otis</u> b. (Middle) <u>W.</u> c. (Last) <u>Webb</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2/15/55</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 28, 1890</u>	9. AGE (In years last birthday) <u>64</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationery Eng. Booth Cold Storage Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Moses Webb</u>		13b. MOTHER'S MAIDEN NAME <u>Delphia Hollingsworth</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys N.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW #1</u>		16. SOCIAL SECURITY NO. <u>702-12-7445</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Gladys N. Webb--4159 Taft Ave.</u>		
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Decubus</u> <u>Cerebral Sclerosis.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 15, 1955</u> , to <u>Feb 15, 1955</u> , that I last saw the deceased alive on <u>Feb 12, 1955</u> , and that death occurred at <u>5:15P</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>J. Earl Smith M.D.</u>			23b. ADDRESS <u>539 N. Grand St. St. Louis</u>		23c. DATE SIGNED <u>2/17/55</u>
24a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Removal</u>		24b. DATE <u>2/18/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>
DATE REC'D BY LOCAL REG. <u>FEB 17 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Welderle 3634 Gravois Ave</u>	

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

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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 *Robert Wheeler*.....

Licensed Embalmer No. *212*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.