THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 5 - 1958

58-006982
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2095

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis City Hospital #1 — Length of stay in 1b: 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO. b. COUNTY:
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3985 SCHILLER PL. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Albert Middle: W. Last: Babb

4. DATE OF DEATH: Month Day Year: Feb. 20, 1958

5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-8-1879
9. AGE (In years last birthday): 78 — 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): GENERAL WORK
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (City and state or country): MAYFIELD, KY.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: FRANK BABB
13b. MOTHER'S MAIDEN NAME: BETTY SAWYER
14. NAME OF HUSBAND OR WIFE: CORDA BABB

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 490-14-8996
17. INFORMANT: ROBERT BABB Address: 1211 PEMBROKE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 443X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bleeding Duodenal Ulcer - Chr. pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-18-58, to 2-20-58 and last saw her/him alive on 2-20-58
Death occurred at 4:05 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John C Doubek Jr. M.D.
22b. ADDRESS: 1515 Lafayette Ave.
22c. DATE SIGNED: 2-20-58

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 2-24-58
23c. NAME OF CEMETERY OR CREMATORY: MT. LEBANON CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO. MO.

24. FUNERAL DIRECTOR: KRIEGSHAUSER ADDRESS: 4228 S. KINGSHIGHWAY
25. DATE RECD. BY LOCAL REG.: FEB 21 '58
26. REGISTRAR'S SIGNATURE: J Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Richard W. Stoveson

Licensed Embalmer No. 4007

P. O. Address .....

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.