

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

'59 0 4 6 0 6 5

211438

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 213 Ferry St. | |
| | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First LOUIS Middle Last WEBB | | | 4. DATE OF DEATH Month Dec. Day 9 Year 1959 | | |
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|------------------------------|---|---|--|--|--|-------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-11-1904 | 9. AGE (last birthday) 55 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
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| 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 (City and state or country) Reynolds Co. Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME William Webb | 13b. MOTHER'S MAIDEN NAME Mary Williams | 14. NAME OF HUSBAND OR WIFE Minnie Webb |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 499-01-8827 | 17. INFORMANT Minnie Webb | Address 213 Ferry St. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH 6 months |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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|--|------------------------|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
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|--|---|-------------------------------------|---------------|--------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 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 **Nov. 1, 1959** to **Nov 18, 1959** and last saw her/him alive on **November 18, 1959**
Death occurred at **4 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Francis J. Carey M.D. | (Degree or title) | 22b. ADDRESS 1515 Lafayette | 22c. DATE SIGNED 12/11/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Dec. 11 1959 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | 23d. LOCATION (City, town, or county) St. Louis Co. Mo. |
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| 24. FUNERAL DIRECTOR Leidner Undertaking 2223 St. Louis Ave. | ADDRESS | 25. DATE RECD. BY LOCAL REG. DEC 10 1959 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. (H.T.) |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St Louis

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.