

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 30 1960

60-013492

REGISTRAR'S No. 952 STATE FILE NUMBER 60-013492

Registration District No. 317 Primary Registration District No. 544

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u> | | Length of stay in 1b <u>D.O.A.</u> | c. CITY OR TOWN <u>Kirkwood</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA St. Joseph Hosp.</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>911 So. Harrison</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Lucious Emory</u> Middle <u>Webb</u> Last <u>Webb</u> | | | 4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>21 May 1903</u> | 9. AGE (last birthday) <u>57</u> | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Nashville, Tenn.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>Matthew Webb</u> | | 13b. MOTHER'S MAIDEN NAME <u>Ellissa Burnett</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sarah J. Webb</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>488-34-3912</u> | 17. INFORMANT <u>Saran J. Webb, 911 So Harrison</u> Address | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> | | |
| DUE TO (b) <u>Hypertensive and arteriosclerotic heart disease</u> | | <u> </u> years |
| DUE TO (c) <u> </u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 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 type="checkbox"/> NO <input checked="" 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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 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 <u>2-1-55</u> | 20f. CITY, TOWN, OR LOCATION <u>3-17-60</u> | 20f. CITY, TOWN, OR LOCATION <u>3-8-60</u> |
| 21. I attended the deceased from <u>2-1-55</u> to <u>3-17-60</u> and last saw her/him alive on <u>3-8-60</u> Death occurred at <u>8:00</u> P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE <u>Robert A. Doney M.D.</u> (Degree or title) | | 22b. ADDRESS <u>126 E. Jefferson Kirkwood, Missouri</u> | 22c. DATE SIGNED <u>3-19-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>22 Mar. 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Reliable Funeral Svcs. 1380 N. Union</u> | 25. DATE RECD. BY LOCAL REG. <u>MAR 21 1960</u> | 26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u> | |

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 Paul V. Freeman

Licensed Embalmer No. 4686

P. O. Address 1389

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.