

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033430

FILED VS SEP 12 1960

317

Primary Registration District No.

500

Registrar's No.

2352

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis City</b> )									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo</b>		Length of stay in 1b <b>7 1/2 months</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rob't Koch Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>5300 <del>Central</del> St. Louis Chronic Hosp</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>FOREST</b> <sup>First</sup> <b>Hunter</b> <sup>Middle</sup> <b>(none)</b> <sup>Last</sup> <b>Webster</b>				4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>60</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-3-92</b>		9. AGE (last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (City and state or country) <b>Missouri</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Wayne Webster</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Johnson</b>				14. NAME OF HUSBAND OR WIFE <b>Josie Ties Webster</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I - 2 1/2 days</b>				16. SOCIAL SECURITY NO. <b>486-12-9384</b>		17. INFORMANT Address <b>Records Koch Hosp., Koch, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus, Chronic Brain Syndrome</b>										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			
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				COUNTY		STATE			
21. I attended the deceased from <b>12-24-59</b> to <b>8-5-60</b> and last saw him alive on <b>8-5-60</b> Death occurred at <b>11:40</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>H.A. Harris MD.</b>				22b. ADDRESS <b>Koch Hospital, Koch, Mo</b>				22c. DATE SIGNED <b>8-5-60</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Noter</b>		23b. DATE <b>8/7. 60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ELESBERRY . MO</b>		23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR <b>PORTER FUNERAL. 3028 Dickson ST</b>				25. DATE RECD. BY LOCAL REG. <b>8-5-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. Ta

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.