

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015832

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1223

**FILED MAY 8 1961**

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>WKS.</u>	c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>901 Greeley Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK WILLIAM BUBB</u>			4. DATE OF DEATH Month Day Year <u>May 1, 1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>7-3-1892</u>
9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consultant (Science)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	11. BIRTHPLACE (City and state or country) <u>Nevada Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Lewis W Bubb</u>	
13b. MOTHER'S MAIDEN NAME <u>Lula Bunker</u>		14. NAME OF HUSBAND OR WIFE <u>Hulda Margaret Bubb</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>		17. INFORMANT Address <u>Mrs. F.W. Bubb 901 Greeley Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic ca. of lung</u> DUE TO (b) <u>Cancerous of colon.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>at work</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
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.)	
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 <u>NOT 1958</u> to <u>MAY 1-61</u> and last saw <sup>her</sup> him alive on <u>JUN 1-61</u> Death occurred at <u>10:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Frank Williams M.D.</u>		22b. ADDRESS <u>4161 Kuster</u>	22c. DATE SIGNED <u>5.2.61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-3-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich Webster Groves Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-2-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

JUL 17 1961.

**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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Wester Groves

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.