

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-019599

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5108 STATE FILE NUMBER

FILED JUN 8 1961

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Months	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles		First	Middle	Last Webb	4. DATE OF DEATH Month May Day 29 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1877		9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Retired		10b. KIND OF BUSINESS OR INDUSTRY Bridge Carpenter		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Joseph Webb		13b. MOTHER'S MAIDEN NAME Elizabeth Stephens			14. NAME OF HUSBAND OR WIFE Eva		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish-American		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Goewert 4983 Heege ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent Cerebral apoplexy		DUE TO (b) arterio-sclerotic Heart Disease		DUE TO (c) Left sided hemiplegia		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) fracture surgical neck left femur		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.) Fell at home 420.0 F					
20c. TIME OF INJURY Hour a.m. p.m. 3-246		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.) Home		20f. CITY, TOWN, OR LOCATION St. Louis	
21. I attended the deceased from 9/1/60 to 5/29/60 and last saw him alive on 5/29/60		Death occurred at 4.30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE George A. O'Sullivan, M.D.		(Degree or title)		22b. ADDRESS 7629 Ivory ave		22c. DATE SIGNED 5-29-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 1, 1961		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.	
24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries		ADDRESS 7814 S. Broadway		25. DATE RECD. BY LOCAL REG. MAY 31 1961		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

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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 John P. Dennehy
Licensed Embalmer No. 4194
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.