

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029287

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6788**

FILED JUL 31 1962

VS 300
Rev. 4/59

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- 2 *211*
- 3
- 4 *2*
- 5 *1*
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- 8 *1*
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- 12 *92-3*
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|---|--|---|------------------------------------|--|---|--------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY |
| | | St. Louis | | 45 yrs | Missouri | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| D.O.A. Homer G. Phillips | | | | | 1928 Belle Glade | | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH Month Day Year | |
| | | | JAMES | CHELSEA | WEBB, JR. | July 6 1962 | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR Months Days Hours Min. |
| Male | Col | | 10-15-1902 | | 59 | | 8 21 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | |
| Core Maker | | Scullins Steel | | Little Rock, Ark. | | U.S.A. | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | |
| James Chelsia Webb | | | Paulina Andrews | | | LaVaughn Webb | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| No | | | | HA | | James C. Webb, III 4046a Labadie Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 1. Myocardial Infarction | | | | | | | |
| 2. Coronary Artery Disease | | | | | | | |
| 3. Chronic Myocarditis | | | | | | | |
| 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 |
| 4201 | | | | | | | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | 22b. ADDRESS | | 22c. DATE SIGNED | |
| <i>Rep. on Duty</i> | | | | 1000 Clark | | 7-10-62 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | |
| Removal | | 7-11-1962 | Father/Dickson | | St. Louis Co. Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | |
| JAS. H. RANDIE & SON 3133 Bell Ave. | | | | JUL 10 1962 | | Karl Smith M.D. | |

USE BLACK INK OR TYPEWRITER RIBBON

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 Esther H. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.