

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6228**
1619
Registrar's No.

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 2305 So 10th St.	

3. NAME OF DECEASED (Type or Print) a. (First) RUBY b. (Middle) PEARL c. (Last) BECK	4. DATE OF DEATH (Month) (Day) (Year) FEB. 18, 1952
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid	8. DATE OF BIRTH 2-28-08	9. AGE (In years last birthday) 43 If under 1 year: Months _____ Days _____ If under 12 mos: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hickman, Ky	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME William Webb	13b. MOTHER'S MAIDEN NAME Laura Jackson	14. NAME OF HUSBAND OR WIFE James W.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Ruth Bynum	ADDRESS 1823 Benton St., St. Louis
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 years 15 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cox pulmonale		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchial asthma DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 24HX
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22. I hereby certify that I attended the deceased from **2-11-52**, 19___, to **2-18-52**, 19___, that I last saw the deceased alive on **2-18-52**, 19___, and that death occurred at **12:28PM**, from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) John T. Lawton, M.D.	22b. ADDRESS 1515 Lafayette Avenue	22c. DATE SIGNED 2-18-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-21-52	24c. NAME OF CEMETERY OR CREMATORY National Cem.	24d. LOCATION (City, town, or county) (State) Jefferson Bks., Mo.
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DATE REC'D BY LOCAL OFFICE FEB 20 1952	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin's	ADDRESS 2301 Lafayette Ave. St. Louis
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WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed _____

A. G. Farris

Licensed Embalmer No. *3384*

P. O. Address *2301 Lafayette*

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 this body is not embalmed, fact should be so stated above.