

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36977**
9943
Registrar's No.

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2823 Stoddard	

3. NAME OF DECEASED (Type or Print) a. (First) Bessie b. (Middle) c. (Last) Webb	4. DATE OF DEATH (Month) (Day) (Year) Oct. 27 1952
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 24, 1901	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 3	IF UNDER 1 YEAR Days 3	IF UNDER 1 HR. Hours	IF UNDER 1 HR. 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 none	11. BIRTHPLACE (City and State or Foreign Country) Oaklahoma	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Willie Schurk	13b. MOTHER'S MAIDEN NAME Susie Wynn	14. NAME OF HUSBAND OR WIFE Willie R Webb
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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.	17. INFORMANT'S SIGNATURE OR NAME Pennie Ward	ADDRESS 2828 Dickson St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Insufficiency		
	ANTECEDENT CAUSES DUE TO (b) Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Luetic Heart Disease; Hypertension			

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 023X

22. I hereby certify that I attended the deceased from **9-8**, 19**52**, to **10-27**, 19**52**, that I last saw the deceased alive on **10-27**, 19**52**, and that death occurred at **4:05 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Edwin E. Brooks	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 10-27-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 10-3-52	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Missouri
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 29 1952 J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home	ADDRESS 2820 Stoddard St.
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WRITE PLAINLY—USING UNFADING 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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address Albany 13

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.