

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34275

FILED SEP 24 1953

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1003

State File No. 8156

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____								
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. LENGTH OF STAY (in this place) 2 Months		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital				e. STREET ADDRESS (If rural, give location) 13 5400 Arsenal Street										
3. NAME OF DECEASED (Type or Print) Tilda Webb			a. (First) Webb			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) August 21, 1953		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH: January 6, 1882		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (City and State or Foreign Country) Wellsville, Missouri			12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME Shelton Haislip				13b. MOTHER'S MAIDEN NAME Sarah Jane Yarnell				14. NAME OF HUSBAND OR WIFE James Webb						
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 ADDRESS James Webb, 2319 S. 12th. St. Louis, Mo.								
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative infection rt. inguinal region Bilateral bronch-pneumonia with fibrous pleurisy DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH 6 days 5 days		
19a. DATE OF OPERATION 8-9-53				19b. MAJOR FINDINGS OF OPERATION Incarcerated right inguinal hernia				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
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) 561.0										
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?										
22. I hereby certify that I attended the deceased from 6-8, 19 53, to 8-21, 19 53, that I last saw the deceased alive on 8-21, 19 53, and that death occurred at 2:50a. m., from the causes and on the date stated above.														
23a. SIGNATURE (Degree or title) <i>W. K. Bush, M.D.</i>				23b. ADDRESS 5400 Arsenal Street				23c. DATE SIGNED 8-21-53						
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-24-1953		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Wellsville, Missouri								
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <i>D. Earl Smith, M.D.</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin's, 2301 Lafayette, St. Louis, Mo.								

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

300  
48

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..... *James R. Chapman*

Licensed Embalmer No. *4*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.