

XC-19 787 345

STANDARD CERTIFICATE OF DEATH

36367

SL-10400 FILED NOV 16 1956

318

STATE FILE NUMBER

1003

8941

Registration District No. Primary Registration District No.

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST. CLAIR			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		c. CITY OR TOWN EAST ST. LOUIS 8/20		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vet. Adm. Hospital		Length of stay in 1b 93 days		d. STREET ADDRESS 48 (Rear) St. Clair (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GROVER Middle - Last WEBB			4. DATE OF DEATH Month 9 Day 27 Year 56		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-89	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) FAYETTE COUNTY, TENN. / 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY WEBB			14. MOTHER'S MAIDEN NAME DOLLY BAILEY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW-1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address VA HOSP. RECORDS, 915 N. GRAND, ST. LOUIS, MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR FAILURE</u>					INTERVAL BETWEEN ONSET AND DEATH Undetermined
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA OF RECTUM, RECURRENT</u>					II
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					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 Month, Day, Year a. m. p. m.					
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. / VA attended the deceased from 6-26-56 to 9-27-56 and last saw her him alive on 9-27-56		Death occurred at 2:40 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hy P. Westphal M.D. (Doctor or title)		22b. ADDRESS 915 N. Grand, M.D. VA Hosp. St. Louis, Mo.		22c. DATE SIGNED 9-28-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9/29/56		23c. NAME OF CEMETERY OR CREMATORY Rossville	
23d. LOCATION (City, town, or county) Rossville, Tennessee					
24. FUNERAL DIRECTOR Maronde Office 2114 Mo. Ave St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. SEP 29 1956		26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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 *Ben H. Baldwin*

Licensed Embalmer No. *24*

P. O. Address *721 N. 20*

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.