

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015917
STATE FILE NUMBER
2 3352
Registrar's No.

FILED APR 20 1959

Registration District No. _____ Primary Registration District No. _____

300
1-57
26
98/1
0

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp.		Length of stay in 1b #1 2 days	d. STREET ADDRESS (If outside, give location) 4216 McPherson Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle L. Last Webb			4. DATE OF DEATH Month April Day 1 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1909
9. AGE (In years last birthday) 49		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) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Complete Auto Transit Co.	11. BIRTHPLACE (City and state or country) Olney, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Corothy Webb.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 454-14-7424	17. INFORMANT Address Mrs. Dorothy Webb, 5351 Delmar Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coarctation of Aorta DUE TO (c) 451x			INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Life
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. I attended the deceased from March 30, 1959 to April 1, 1959 and last saw ^{her} alive on April 1, 1959 Death occurred at 9:32 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John W. Smith MD (Degree or title)		22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 4/2/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE April 1, 1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Chapel Memories	23d. LOCATION (City, town, or county) (State) St Louis County, Missouri
24. FUNERAL DIRECTOR Shepard Funeral Home, 1167 Hamilton Ave		25. DATE RECD. BY LOCAL REG. APR 4 '59	26. REGISTRAR'S SIGNATURE John W. Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

D.P.

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 

Licensed Embalmer No.

P. O. Address... ..

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.