

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015918

STATE FILE NUMBER

23177

FILED APR 20 1959

Registration District No.

Primary Registration District No.

Registrar No.

300
1-57

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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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 818 Anggelica	

3. NAME OF DECEASED (Type or print) First Middle Last LOTTIE WEBB			4. DATE OF DEATH Month Day Year March 28, 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> & DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-1886	9. AGE (In years at birthday) 72	10. FUNDER YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during last of working life or if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Washington Albritton	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Asahel
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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. NONE	17. INFORMANT Address May Helms -1212 Wright Street
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> DUE TO (b) <i>Arterio sclerotic Heart Disease</i> DUE TO (c) <i>Arterio sclerosis 420.0</i>		INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Patrick Taylor Carner</i> (Degree, title) 3	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 3.30.59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/30/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette Ave.	25. DATE RECD. BY LOCAL REG. MAR 30 '59	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MEDICAL CERTIFICATION

m y B

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. *4550*
P. O. Address *St. Louis*

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.