

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36105

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8567**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St. Louis		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 City Hospital #1		STREET ADDRESS (If rural, give location) 3 7020 Lansdowne			

3. NAME OF DECEASED (Type or Print) PERCY LEE WEBB			4. DATE OF DEATH Sept. 17, 1954	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 12, 1877	9. AGE (In years last birthday) 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad Industry	11. BIRTHPLACE (City and State or Foreign Country) Charleston, South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA				

13a. FATHER'S NAME Thomas Webb	13b. MOTHER'S MAIDEN NAME Mary Parrish	14. NAME OF HUSBAND OR WIFE Anna Webb
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) yes Spanish-American	16. SOCIAL SECURITY NO. 703-01-2936	17. INFORMANT'S SIGNATURE OR NAME Genevieve Kaufman, 7020 Lansdowne,	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Emphysema DUE TO (c) Bronchial Pneumonia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inanition			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 491X
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22. I hereby certify that I attended the deceased from Aug. 25, 1954, to Sept. 17, 1954, that I last saw the deceased alive on Sept. 17, 1954, and that death occurred at 5:35 P.m., from the causes and on the date stated above.

23. SIGNATURE Marion G. Austin, M.D. (Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 9/17/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sept. 21, 1954	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri
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DATE REC'D BY LOCAL REG. SEP 20 1954	REGISTRAR'S SIGNATURE Charles Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	ADDRESS Colonial Mortuary, Chippewa
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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
Signature of Student Embalmer

Signed *Louis C. Hoffmann*

Licensed Embalmer No. *387*

P. O. Address *7814 S. 1st*

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.