FILED JAN 23 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3768
STATE FILE NUMBER 469

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Length of stay in Hospital or Institution: 44

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1928 Belleglade — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Leon; Middle:; Last: Webb
4. DATE OF DEATH: Month 1, Day 9, Year 58
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 6, 1911
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months 8, Days 3 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY: Taxi Cab
11. BIRTHPLACE (City and state or country): Alton, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James C. Webb
14. MOTHER'S MAIDEN NAME: Paulina Andrews
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 499-01-2854
17. INFORMANT: James C. Webb, Jr. Address: 1928 Belle Glade

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis with Right Hemiplegia — undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Atrophy, Progressive
19. WAS AUTOPSY PERFORMED? YES ☐ NO XX 2
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1-3-58 to 1-9-58 and last saw him alive on 1-9-58
Death occurred at 8:08 P m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: Sydney A. Jones, M.D. (Degree or title)
22b. ADDRESS: 2601 Whittier Street
22c. DATE SIGNED: 1-11-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 15, 1958
23c. NAME OF CEMETERY OR CREMATORY: Father Dickson
23d. LOCATION (City, town, or county): St. Louis County (State): Mo.
24. FUNERAL DIRECTOR: J. H. RANDLE & SON — ADDRESS: 3133 Bell Ave.
25. DATE RECD. BY LOCAL REG.: JAN 14 '58
26. REGISTRAR'S SIGNATURE: J. Carl Smith, MD

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Esther T. Harres

Licensed Embalmer No. 44

P. O. Address 481 Was

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.